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The Wisconsin Medical Journal

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A Monthly Journal of Medicine and Surgery

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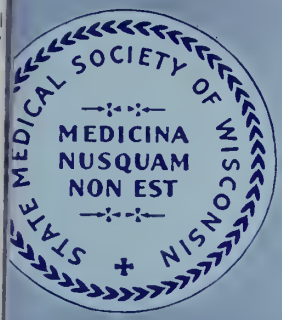

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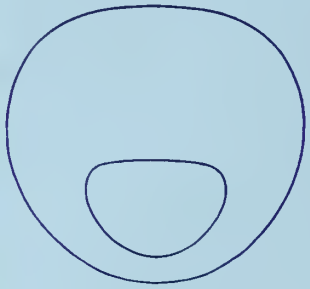

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THE WISCONSIN MEDICAL JOURNAL

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Number 1

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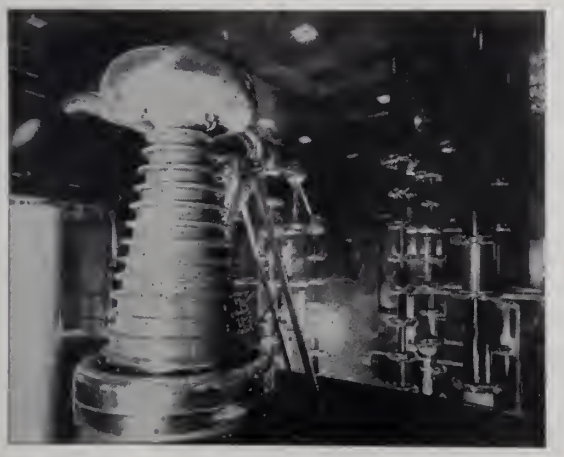

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[1]NARODICK, P. H. (Supt. and Med. Director, King County Tuberculosis Hosp., Seattle, Wash.): Northwest Med. 41:193 (June) 1942.

[2]COHEN, P. (Santa Barbara County Health Dept., Santa Barbara, California): California & West. Med. 56:70 (Feb.) 1942.

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*J.A.M.A., 93:1110—October 12, 1929
Brückner, H.—Die Biochemie des Tabaks, 1936
The Military Surgeon, Vol. 89, No. 1, p. 5, July, 1941

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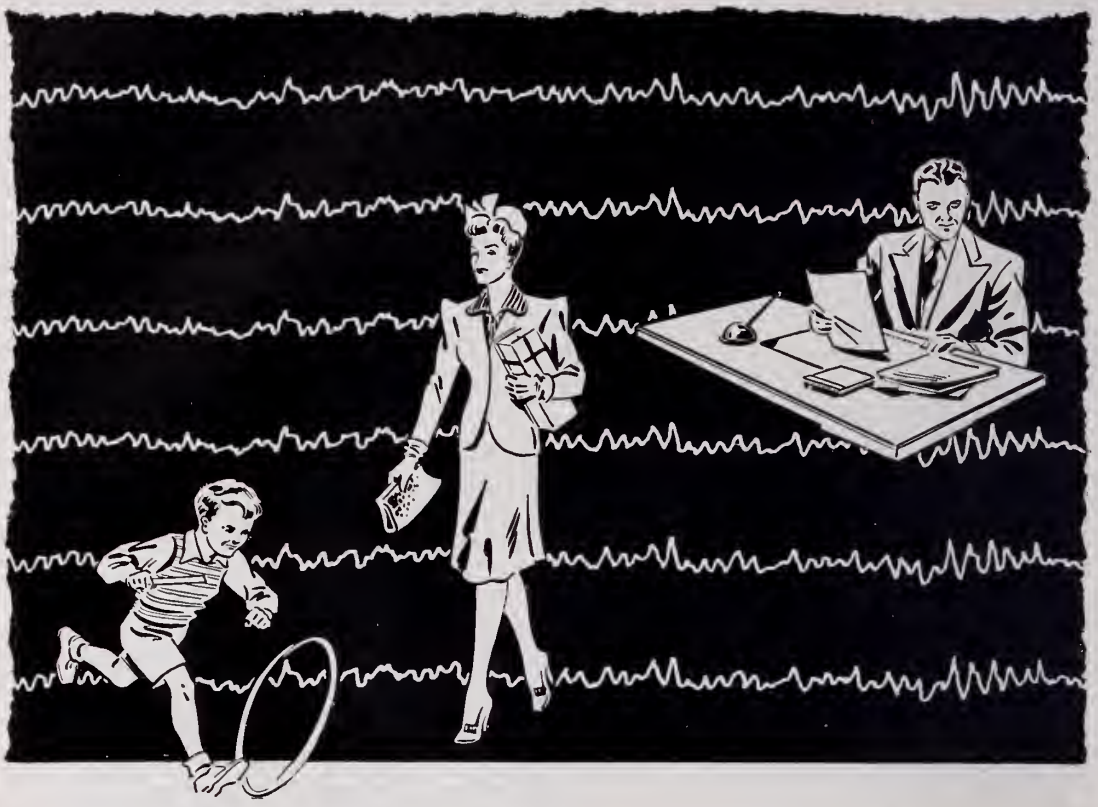

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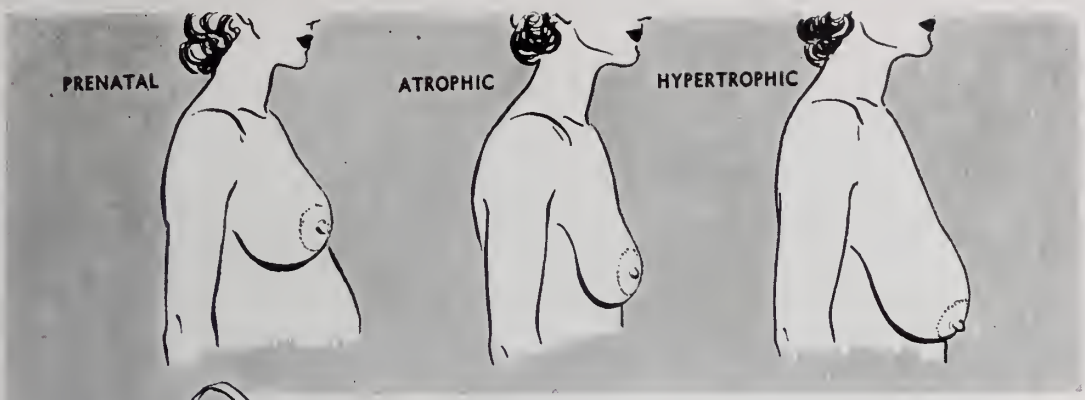
1. Palmer, H. D. & Hughes, J.: *The Penn. Med. J.*, Aug. 1942



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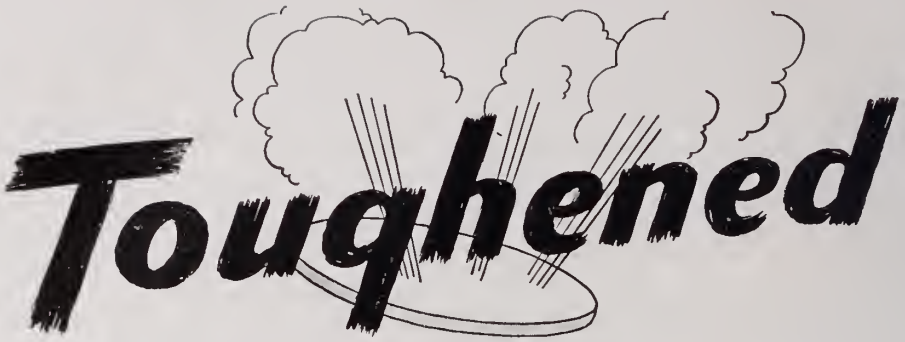

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** Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154; Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60*

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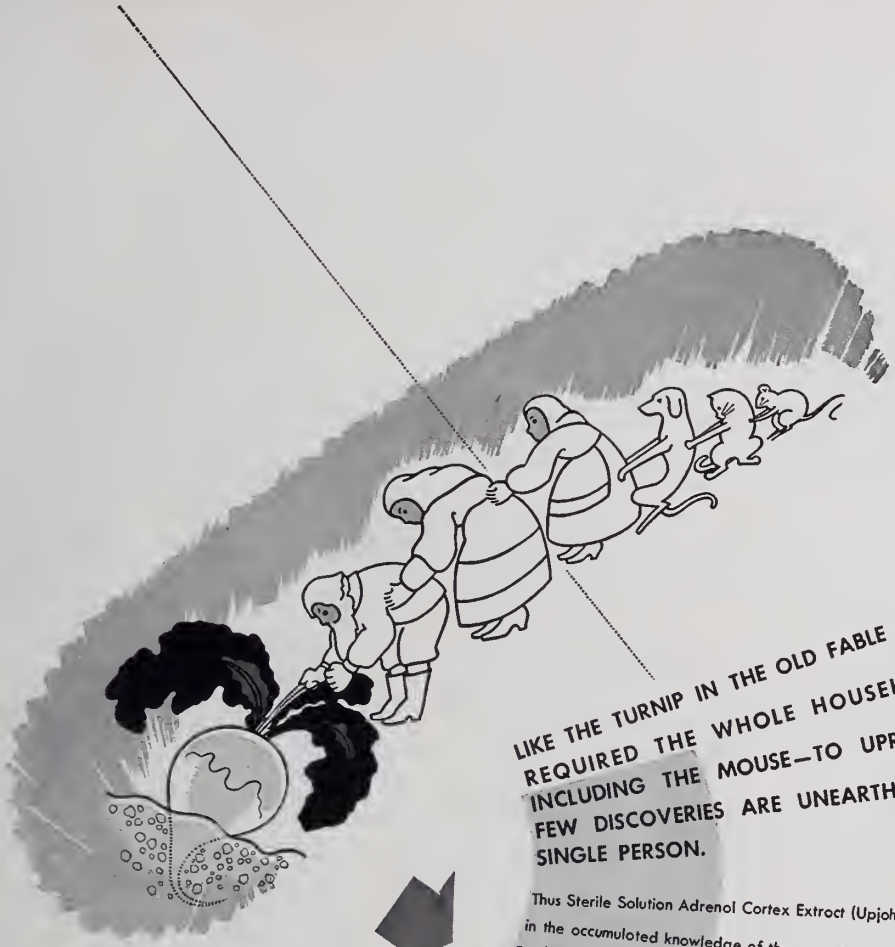

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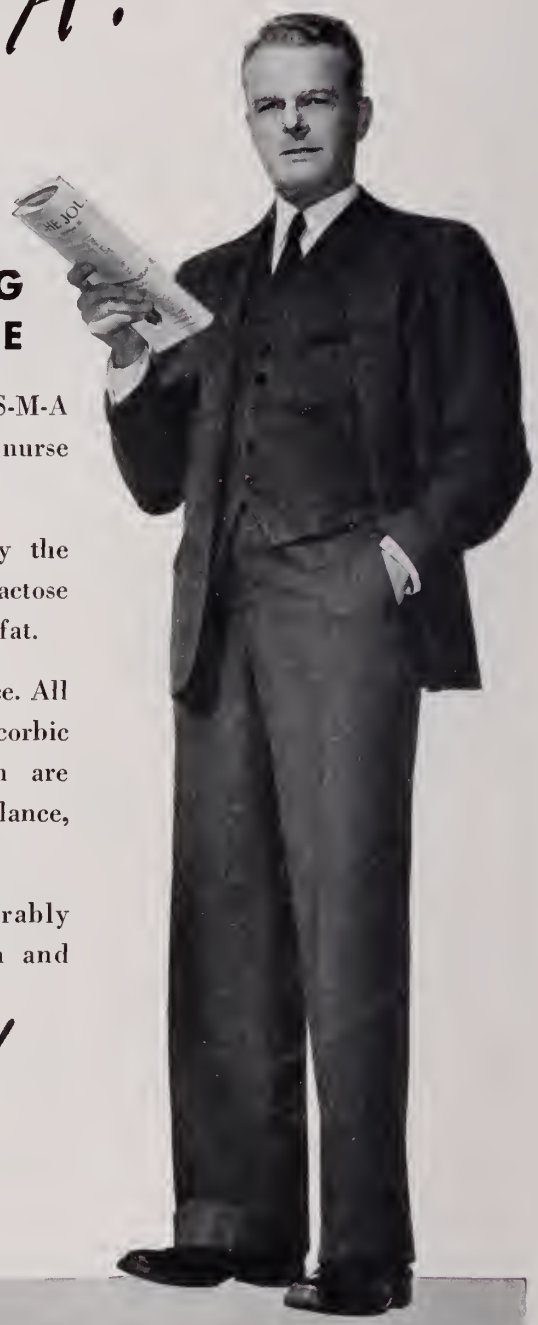

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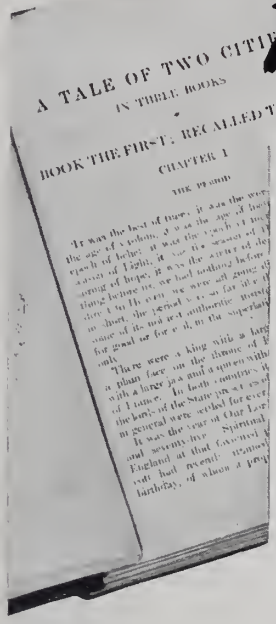

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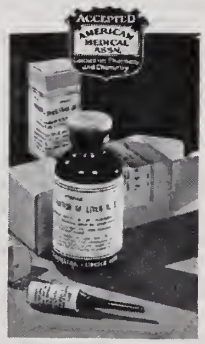

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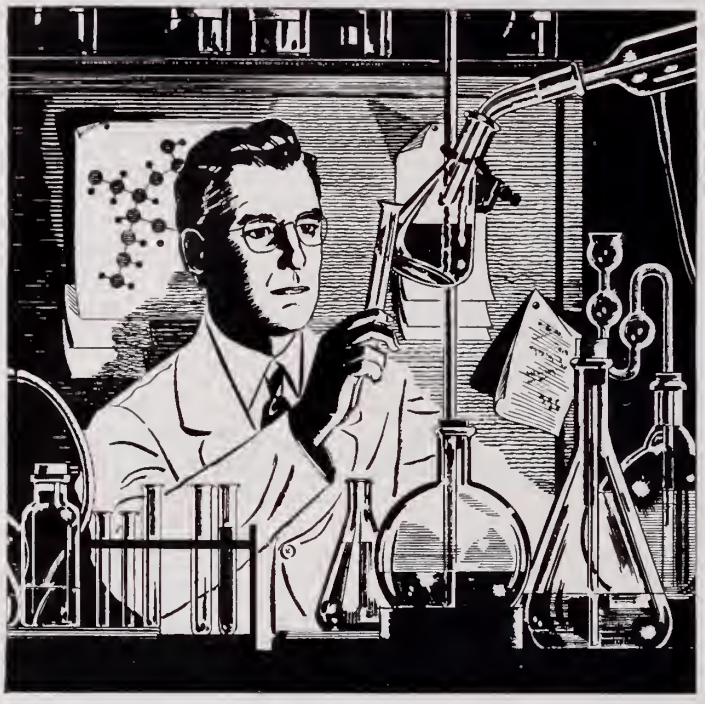

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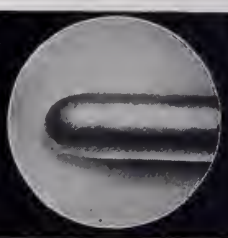

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THE WISCONSIN MEDICAL JOURNAL

VOLUME 42, NO. 1 Copyright, 1943, by The State Medical Society of Wisconsin JANUARY, 1943

THE 1943 BLUE BOOK

An Introduction

IT IS a pleasant task to usher in the new year with the Blue Book issue of *The Wisconsin Medical Journal,* which, this year, is divided into three parts, separated from one another by tabs for the convenience of the physician reader. The issue contains much new material, and an effort has been made to strike a balance between the more transitory and the more permanent.

History of Society

The first part contains a summary of some of the activities, achievements, and dates which serve as milestones in the history of our Society, of which all of us are justly proud. So extensive is the very number of important events in the life of organized medicine in this state that it was necessary to select with great care what was representative rather than all that was important. It then became essential for reasons of space limitation in the *Journal,* and time limitations on the part of our readers, to give only the substance of those episodes from our Society history which represent the onward and upward march, not merely of our profession, but also of the health of Wisconsin's successive generations.

It was an inspiring experience to work through the records of our Society and to cull from those records what is presented in the following pages. We hope you will derive both inspiration and a measure of pardonable pride from those pages. By reading and absorbing that story each member should find that it serves to reaffirm in him a lifelong devotion to his profession and to strengthen his sense of helping carry on a tradition of service which is both challenging and distinguished.

It is not by accident that the story of organized medicine in Wisconsin and its legislative recognition begins even before our state existed as such, and that it has continued without interruption throughout the history of this commonwealth.

Medical Economics and Organization

The second part of this issue contains the material of the type which is familiar from earlier Blue Books. There can be nothing static about a Blue Book section during this period of daily changes. There is such entirely new material as that dealing with 1942 federal wage and salary regulations and with the 1943 Victory Tax. In some instances the articles are so completely rewritten that they retain little more than their titles from the previous Blue Book. This is notably true of such articles as those dealing with income taxes, with the amended provisions of the Soldiers' and Sailors' Civil Relief Act, and with life insurance of the physician in service.

To take but one example, the article on income taxes represents an effort to present, in a form both intelligible and useful to the practicing physician, a subject as complex as it is inescapable. So intricate is this field that even the specialists do not fathom all of its workings. So rapidly is the field changing that in the case of the federal income tax it is estimated that about three-fourths of the article, as printed in this issue, is entirely new or substantially modified. It attempts to a degree, which we believe is not elsewhere exceeded, to assist the physician in an analysis of his chief professional and personal income tax problems.

In order to make room for the inevitable enlargement of some of these articles, and because of the decreased timeliness of others, it was deemed feasible to eliminate from this issue, or to shorten, certain articles which have appeared in earlier Blue Book issues. Thus the article on "Collection of Accounts," appearing at page 1166 of the 1942 issue, has not been printed here. The articles on WPA employee's administration, appearing at page 1223 of the 1942 Blue Book issue, and that on "Medical Witnesses and Expert Testimony," appearing at page 1227 of the same issue, have also been eliminated from the current issue. The articles on "Poor Relief," "Sterilization," and "Narcotics" have all been revised and substantially reduced in length.

No effort has been spared to continue the tradition that the portion of the Blue Book which deals with the economics of practice must be as useful and as valuable as possible to the physician on the home front.

In the latter part of this section of the issue are also to be found the list of officers of state boards and commissions, the officers and committee memberships of the Society, the Society Constitution and By-Laws, the Principles of Medical Ethics, the membership list, and like material which is of convenience to the physician member throughout the year.

Physician in Service

The third portion of the Blue Book is designed for the particular interest of the physician now serving in the armed forces of our country, or for the physician who is preparing to do so. Materials have been brought together in this section for the purpose of assisting such members in placing their professional and personal affairs in order. Thus the section contains a suggested check list for physicians entering service, a detailed analysis of the Soldiers' and Sailors' Civil Relief Act as amended in October, 1942, a careful summary of what the federal government provides with respect to the life insurance program of the physician in service, and an article on allowances, compensation, and related matters of interest to the physician who has not yet been commissioned but who expects to enter the service.

A number of the subjects treated in the economic section of the Blue Book also have implications for the physician in service. Instead of repeating a good deal of the material of which they are a part, it has seemed preferable to incorporate the service aspect of the subject in the fuller article. This is true, for example, of such subjects as income taxes, malpractice and narcotics. The physician interested in checking all the articles under which the problems of a service man are treated in this issue should turn to the index on page 56 and look under the title "Physician in Service."

With this introduction we turn the 1943 Blue Book issue over to you as the reading public for which it was designed and written. Keep it handy for ready reference—it is now your Blue Book.

Records

of the

Wisconsin State Medical

Society

Incorporated

A. D.

1841

A photographic reproduction of the title page of the original longhand records of the Society.

The Records Speak . . .

SUGGESTED by Dr. Gunnar Gundersen in 1941 in his Presidential Address to the House of Delegates, a suggestion reiterated by Dr. Frank E. Butler on the same occasion one year later, this section of the annual Blue Book edition of *The Wisconsin Medical Journal* makes its first appearance. This outline of the first century of progress is the initial step in the direction of developing a current section devoted to the public health and medical economic work of the profession and was largely inspired as a result of the interest shown during the centennial meeting in 1941, when the historical survey of medicine in Wisconsin proved a fascinating topic to the members of that profession.

No more effective introduction could be written than to quote from Dr. Gundersen's address in 1941:

"Many things pass in review—the evolution of science, the romance of the physician as he progresses from empiricism to scientific controls, from the saddle bags to the horse and buggy, from the automobile to the airplane, the triumphs of optimism, the insistence of the highest possible qualification of the doctor of medicine—all stimulate speculation as one meditates as to whether the century ahead can be as remarkable as the century just past.

"Over the radio and in the daily press are broadcast sensational revelations which the public is trying to understand, and if we would keep step with a public which is ever more alert and which is placing ever more demands on the physician, it behooves us all to keep alive to this unfolding medical and surgical drama. The founding fathers of 1841 were just as up-to-date in their day as we are 100 years later as we view with amazement new discoveries which may completely change our conception of medical practice.

"The economic and political stress of the present may be quite as acute as that of any period during our history but it is not new. Seventy years ago the profession of Wisconsin was confronted with trials and tribulations as great as it has ever experienced. In the annual president's address before our Society on June 22, 1871, Dr. H. B. Strong concluded with a statement which rings so true it may well be commended to the profession today:

" 'Medicine is, at present, in the midst of one of these transitions,' declared Dr. Strong, 'and I would have you act honestly and intelligently. The skillful climber holds fast to the present support until he has made sure of his grasp upon the round above, and we, if we would come out of the present transition period of medical practice, at a point above that of our entrance or actual position, must resist the tendency to dishonesty and to extreme views—taking a maxim from a book of the highest authority 'prove all things; hold fast that which is good.'

" 'The danger in transition periods lies in the tendency of the human mind to oscillate to extremes. Tired with familiar exercises and results, captivated by novelties, intoxicated by the inspirations of hope, we rush forward to positions which sober experience proves to be untenable, and in disheartening retreat, lose spirit and courage, as well as the actual fruits we might have secured by more patient and conservative labor. The great problem at such times should be the fusion or amalgamation of the great elements of all existence, stability and progress —the great desideratum, fidelity to our inheritances from the past, and a cordial welcome to the invitations of the future.'

"What could be more appropriate at this period of our growth than to rededicate ourselves and our Society to the proposition of a life of service to our fellow citizens, and during the century ahead join with our state under its banner and slogan 'Forward.' "

No. 53.

AN ACT to incorporate Medical Societies, and for the promotion of Medical Science.

WHEREAS, well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art: therefore,

Be it enacted by the Council and House of Representatives of the Territory of Wisconsin:

SEC. 1. That it shall and may be lawful for the physicians and surgeons, in the several counties of this territory, to meet together on such a day as they or a majority of them shall deem proper, at the place where the last term of the county court, next preceding such meeting, shall have been held in their respective counties; and the several physicians and surgeons, so convened, as aforesaid, or any part of them, being not less than five in number, shall proceed to the choice of president, vice president, recording secretary, corresponding secretary, treasurer and three censors; who shall hold their

County medical societies authorised.

CHAPTER II.

SEC. 1. *And be it further enacted,* That Bushnell B. Cary, M. C. Darling, Lucius I. Barber, Oliver E. Strong, Edward McSherry, E. W. Wolcott, J. C. Mills, David Walker, Horace White, Jonas P. Russell, David Ward, Jesse S. Hewett, B. O. Miller, and their associates, are hereby authorized to meet at Madison, at the capitol of the territory of Wisconsin, on the second Monday in January, 1842, and form themselves into a society under the name and style of the Medical Society of the Territory of Wisconsin, and when met under such name, shall be a body politic and corporate; shall have perpetual succession, and be capa-

Territorial medical society authorised.

A photographic reproduction from the "Laws of Wisconsin."—1841.

An Epitome of the Development and Constructive Work of the State Medical Society of Wisconsin

1841—The Society Created by Territorial Legislature

The Legislative Assembly of the Territory of Wisconsin declared in Act 53 of the Territorial Legislature of 1841 that:

> ". . . , well regulated medical societies have been found to contribute to the advancement and diffusion of true science, and particularly of the healing art . . ."

and by passage of the act it authorized the organization of our Society.

1848—Early Pure Drug Efforts

A resolution memorializing Congress to have all important drugs and preparations inspected and analyzed by chemists is found in the original longhand records of the Society. If discovered to be impure or adulterated they were to be confiscated and destroyed. The resolution was adopted after the problem had been called to the Society's attention by the New York College of Pharmacy.

1849—". . . The advancement and diffusion of true science . . ."

At its annual meeting, the Society recognized the vital importance of continuous medical education and the constant need for the elevation of medical science and training. The Society required that candidates successfully pass an examination as a prerequisite to membership, as an incentive to study.

1850—How the Bureau of Vital Statistics Began

Physicians returning from the "National Medical Convention" of 1847 reported to the Society that they had been urged to have their states secure the registration of births, marriages and deaths. A committee was appointed to present the subject to the legislature and endeavor to secure its passage.

1850—The University of Wisconsin Medical School

The Regents of the University of Wisconsin and the State Medical Society were holding meetings simultaneously in January of 1850, and a representative of the Society was appointed to confer with the Honorable J. H. Lathrop, LL. D., Chancellor of the University, on the subject of organizing and establishing a medical department at the University.

1851—Pioneers in Stamping Out Quackery

A committee was appointed at the meeting of the State Medical Society in 1851 to study means for the protection of the public from "quacks, quackery, patent medicines and nostrums."

1851—Permission to Study Anatomy

The laws of Wisconsin at that time prohibited dissection of human bodies. The Society drafted a bill for presentation to the legislature permitting dissection by medical doctors and students under them to increase their knowledge of human anatomy and surgical science.

1851—The Labeling of Medicines

Further evidence of the Society's interest in proper public health protection is contained in the early longhand records of the organization.

Part of a motion passed at the meeting in 1851 asked that the legislature be petitioned "to pass an act forbidding the sale of any medicine in the state the composition of which is not made known in English upon the wrapper, bottle, or envelope enclosing the same . . ."

1856—The Legislature Asked to Give Care For the Mentally Ill

Even at this early date physicians recognized that so-called "lunatics" were in fact mentally ill, introducing a resolution at the regular meeting of the Society directing that a committee urge the legislature to build a state "lunatic asylum." An amendment was adopted to this resolution substituting the words "hospital for the insane" for the words "lunatic asylum." This was the first of a series of pleas which were made to the Wisconsin legislature for the establishment of an institution or institutions for the care of the mentally ill.

1856—No Patent Profit at the Expense of the Ill

Principles of medical ethics (1942) declare that "it is equally unprofessional by ownership or control of patents or copyrights either to retard or to inhibit research or to restrict the benefit to patients or to the public to be derived therefrom."

The Society, during this formative period by action at its 1856 meeting, frowned upon and refused to sanction the patenting of instruments.

1856—Early Examining Efforts

In order that the public might select only those who were fully qualified and trained in medicine, the State Medical Society adopted the following wording for diplomas issued to members:

"WHEREAS Mr. _____ has exhibited unto the censors of this Society satisfactory evidence that he has studied the Medical and Physical Science for the term and in the manner prescribed by Law, and that he is now qualified to practice the Healing Art with credit to himself and benefit to communities,

"*Therefore, know ye,* That by virtue of the power in us vested by the Laws of the State of Wisconsin, we do hereby grant unto the said _____ this Diploma, together with all the rights, annuities and privileges appertaining to the same."

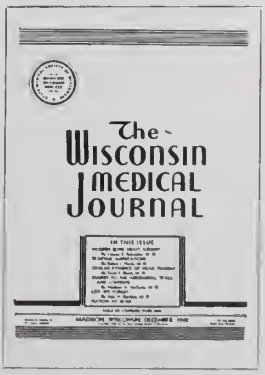
1856—The Beginning of Wisconsin Medical Literature

Members of the Society were required to record histories of all cases of interest. To obtain uniformity in the investigation and reporting of cases, a committee was appointed to prepare the form to be used by the members in keeping the required records.

1857—Chloroform

In the scientific discussions noted in the longhand record of the proceedings of the Society, this date marks the first mention made of anesthesia. The employment of a chloroform mask attracted marked attention at one of the clinical demonstrations.

1860—An Addition to the Family



The Wisconsin Medical Journal was established upon the adoption of a resolution introduced and passed at the 1860 session of the Society. The resolution, outstanding for its brevity, was as follows:

"*Resolved* that in the opinion of this Society a Medical Journal designed to record the experiences of the members of this Society is essential and should be established."

1862–1866—Civil War Interrupts Society Activities

During this period normal Society activities were suspended, as so many of the members were in service, and the increased demand made upon those remaining at home made it inexpedient to hold medical meetings.

1867—Care of Imbeciles is Initiated by the Society

By resolution, the Medical Society at its regular meeting requested that the legislature investigate and determine the number, condition and care of imbeciles in Wisconsin.

1867—Education of Blind Children

Each member of the Society was requested to use his influence in securing the attendance of the blind children in the state at the Wisconsin state institution in order that their education might go forward.

1868—Physicians Join Teachers in Plea For Care of Feebleminded Children

A report of the State Teachers' Association, which was concurred in so enthusiastically by the physicians at that time that they adopted it for their own, provided for the establishment of a school for the feebleminded.

1868—The Medical School Again

President Chadbourne of the state university appeared and suggested that the Society initiate action to establish a medical school at the University of Wisconsin. A resolution was introduced requesting that a committee be appointed to effect the establishment of the medical school. This was laid over to the next meeting of the Society.

1869—No Commercial Diplomas

The legislature had chartered the "Collegiate Agency" in Milwaukee for the sale of diplomas. A committee from the Society was delegated to "memorialize the legislature on behalf of this Society to repeal such charter" as the profession felt that this "agency" was not operated "in accordance with the principles which govern institutions of learning, and we believe such institution to be a fraud and imposture upon the people of Wisconsin."

1869—Protection of the Public From Indiscriminate Sale of Poisons

One of the county medical societies submitted to the State Medical Society a draft of a bill for introduction to the legislature which was designed to prevent the indiscriminate sale of poisons to the public. A committee was appointed to wait upon the legislature and urge the passage of the bill.

1869—The State Board of Medical Examiners is Conceived

The efforts of the preceding twenty-five year period to elevate the standards of medical education in the medical colleges of the country had proved that the proper method was not being followed. Each state society was asked "to appoint, annually, one or more boards of examiners, composed of five thoroughly qualified members, whose duty it shall be to meet at such times and places as they may designate for the examinations of all persons, whether graduates of colleges or not, who proposed to enter upon the practice of medicine in their respective states, except such as have been previously examined and licensed by an examiners' board in some other state."

1870—Dissections Legalized

After repeated attempts over a period of nineteen years, a committee of the Society reports success in obtaining

legislative permission to dissect bodies for the purpose of training physicians and augmenting medical knowledge.

A group of medical students witnessing dissections.

1872—Still Another Addition

The legislature was memorialized by a special committee of the Society to establish "A State Board of Health."

1873—Further Evidence of the Desire to Elevate Medical Education

The American Medical Association was petitioned to "fix some standard which shall govern the admission of every student entering our medical college."

It was declared that at that time there was no authorized standard of preliminary education which was recognized for the student desiring to enter the medical profession.

1873—Obscene Literature

A resolution was introduced to secure the passage at the next session of the legislature of a measure to prohibit the traffic in "obscene literature, illustrations, advertisements, and articles of indecent and immoral use, and obscene advertisements of patent medicine, etc."

1876—Success in the Establishment of the State Board of Health

The committee in charge of memorializing the legislature to establish a State Board of Health reported to the Society that a committee from the Sauk County Medical Society had already progressed so far in obtaining the establishment and passage of such a law that the committee felt "that it was best to confine the matter largely to them." The committee further reported to the State Medical Society that "we are happy to report that as a result of their efforts (the Sauk County Medical Society) a bill was passed which became a law March 31, 1876."

1877—Candidates to Study in Physicians' Offices

Throughout the proceedings during this period resolutions had been introduced to establish requirements for candidates to study medicine in the offices of members of the Society. At this time a resolution was introduced stating that "no candidate for the study of medicine shall be received into the office of any member of this Society as a student of medicine until he shall have received the certificate of the president of the State University or of some one of the presidents of the normal schools of the state that he has educationally qualified to enter upon such professional study."

1878—Anyone Can Practice

The committee appointed to consider the best means for the prevention of quackery and to prevent unqualified persons from practicing medicine in the State of Wisconsin reported that untrained and incompetent persons could practice, but that they could not enforce the collection of their bills. One of the physicians discussing this question stated ". . . anyone can practice medicine who chooses, but he must show evidence of being a graduate of some reputable college or have a certificate from some medical society (county or state) ; otherwise his bill cannot be enforced; which later provision, I understand, has been repealed."

1878—Nicholas Senn Selects For His President's Address the Subject of Medical Legislation to Improve the Public Health

He recommends that laws be enacted to suppress quackery, to regulate the practice of medicine, to establish a state board of medical examiners, and to enforce laws to prohibit improper and illegal practices.

1881—Unqualified Persons Prevented From Using the Title "Doctor"

As an outgrowth of the representations which have been made for the suppression of quackery in the state, a chapter was enacted into the laws of 1881 which prohibited those who had not "received a diploma from some incorporated medical society or college, or shall be a member of the state or some county medical society, legally organized in this state" from using the title "doctor," or referring to himself as physician or surgeon.

1883—The Beginning of Tuberculosis Control

The Society recommended to the State Board of Health that it employ means to have those infected with "consumption" separated from the uninfected members of the family. The resolution provided in part "That in consideration of the efforts made as to the knowledge of the causes of 'consumption,' and of the now known infectious character of the disease, we use all means in our power to have the phthisical members of our families as much as possible separated from the healthy members; . . ."

1886—The "preliminary" Medical School

Emphasizing the "superb facilities" available at the University of Wisconsin, a member of the Society urged that a committee be appointed to confer with the regents concerning the establishment of "a course of preliminary medical study in the university, (it being understood that this is not to be a medical department in any sense of the word.)" This, the Society was advised, ". . . would do more than anything else to elevate the standard of medical education in this state . . ."

The following year a resolution was adopted urging the Regents of the University of Wisconsin to establish a premedical course of two types. The first course would be "an introduction to the study of medicine," the other a two year course "preparatory to medicine but not leading to a degree." The latter course of study was designed apparently to accommodate the student who wished later to take his final training in the office of a physician.

1887—Physicians' Early Efforts to Establish an Institution For the Care of "idiots and feebleminded" is Vetoed by the Governor

A special committee, having been so authorized at the previous meeting of the Society so to do, prepared a bill for the legislature which asked for the erection of an institution for the care of the "idiots and feebleminded." The bill, which was passed only to be vetoed, provided for an appropriation of $20,000. The physicians of that day declared, "Now it is necessary for this Society and all who are interested in this matter to do what they can do to publish information throughout the state in regard to this class."

1889—By a Vote of 41 to 39 the Assembly Refuses to Pass the Society's Bill to Establish the State Board of Medical Examiners

Upon the request of the committee authorized to prepare and introduce to the legislature a bill "To Prevent Incompetent Persons From Commencing the Practice of Medicine in the State of Wisconsin," the following notation appears as a prelude to the full bill which is contained in the Society's transactions:

"NOTE.—In connection with the foregoing remarks the Committee on Publication, desiring that the Society's progress, in its endeavor to procure the passage of a bill regulating the practice of medicine and surgery in this state, should appear in its transactions from year to year, and constitute a record of the matter, decided that this was a proper place to print the bill, as finally amended and presented to the legislature."

In commenting upon their efforts to secure the passage of the bill to establish the Board of Medical Examiners the committee stated:

"The bill was brought before the assembly for action on April 5, 1889. It was laid upon the table by a vote of 41 to 39. One of the members of the committee, who reported favorably on the bill, left the assembly chamber before the vote was taken. Mr. Solon, who voted and talked against the bill, supported it in the early part of the session. Had these two members of the committee supported the bill there would have been a tie vote, which would have been decided in our favor by the speaker, who was in favor of the bill."

A vote of confidence was given the committee with the implied instruction to continue until successful.

1895—For the Public's Protection ". . . a high standard should be required of the practical pharmacists of the state . . ."

The chairman of the committee appointed to confer with the Board of Regents in regard to the school of pharmacy stated at the forty-ninth annual session of the Society: that "it is proper and fitting for the medical profession represented in this Society to express as its opinion in regard to this matter that a high standard should be required of the practical pharmacists of the state." The resolution which was adopted by the Society at that time provided in part as follows:

"*Resolved,* That in our opinion every pharmacist in charge of a drug store or pharmacy should be a graduate of a recognized pharmaceutical school or college.

"*Resolved,* That in our opinion the Pharmacy Act should be so amended as to require that hereafter every applicant for examination as licentiate in pharmacy before the State Board should be required to present a diploma from a recognized school of pharmacy before he is allowed to take the examination."

A licensed pharmacist at work.

1895—Diphtheria Control—State Board of Health Requested by Society to Establish Bacteriologic Stations Throughout the State

At this meeting of the Society a resolution was introduced that provided for the appointment of a committee from the Society to confer with the State Board of Health concerning the "feasibility of establishing bacteriologic stations throughout the State, whose function shall be the investigation of the cause and treatment of diphtheria, and that such committee report at our next meeting."

1896—Scientific Medical Research Threatened by Antivivisectionists

The State Medical Society of Wisconsin endorsed the position taken by the American Medical Society in opposition to the passage of federal legislation prohibiting vivisection. A bill had been introduced in congress which would have prevented vivisection.

1896—The Society Initiates Legislation to Prevent Blindness in Infants

In moving for the adoption of a resolution which made the Society the champion of the cause of prevention of infant blindness in Wisconsin the following statement was made: "I think it is a very important matter and one that should be impressed upon the people of the State."

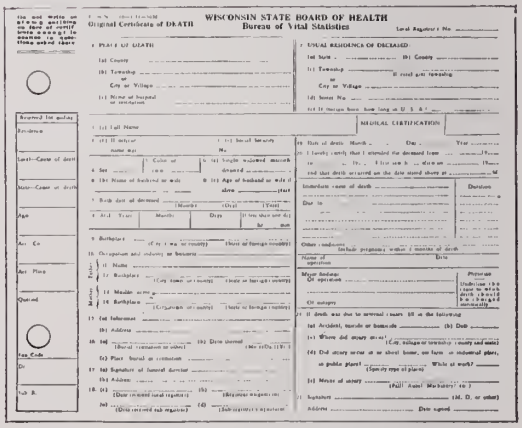
The resolution declared that:

> "WHEREAS, There are in the United States several thousand who have become blind because of ophthalmia neonatorum; and
>
> "WHEREAS, This unfortunate result is largely preventable, being due to the neglect of nurses and midwives, therefore . . ."
>
> The Society appointed a committee which was authorized to seek legislation which would tend to lessen the blindness caused by ophthalmia neonatorum. The law provided that it became the responsibility of the person, nurse or midwife having charge of the infant to report all cases of inflamed eyes to the "Commissioner of Health" or to some legally qualified practitioner.

1896—Trouble With Vital Statistics

". . . but the laws regulating the registration of births and deaths are practically dead letters on our statute books, . . ." was the declaration of U. O. B. Wingate, then secretary of the State Board of Health, in appealing to physicians to support and assist in the passage of a bill designed to obtain a thorough and complete record of our births and deaths. The records at that time were incomplete, and to obtain compliance the bill was introduced in the legislature. But the secretary of the State Board of Health had this to say . . . "The following bill was introduced by the State Board of Health at the last session of the legislature as a remedy for this state of affairs, but I think it was killed in committee, by undertakers, on the ground that it would add too much to their duties . . ."

The Society voted to support a similar bill if introduced.


WISCONSIN STATE BOARD OF HEALTH
Bureau of Vital Statistics
Original Certificate of DEATH
MEDICAL CERTIFICATION

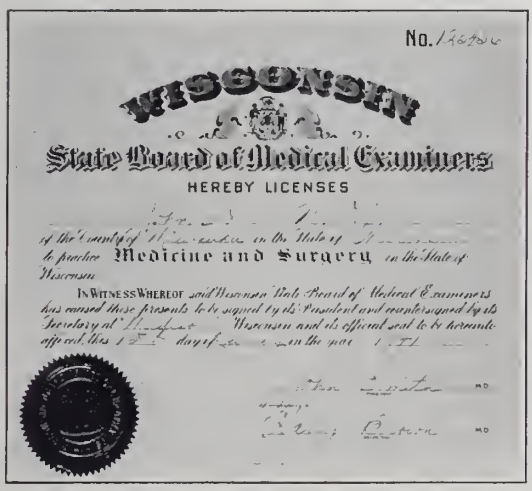
"Certificate of Death"
Wisconsin State Board of Health
Bureau of Vital Statistics

1897—The Plea For a State Board of Medical Examiners is Finally Answered After Twenty-Eight Years of Continuous Effort

Spread upon the record of the Society's proceedings of 1897 is Chapter 264 of the laws of that session of the legislature, the title of which read: "AN ACT to regulate the practice of medicine and surgery in the state of Wisconsin."

So another chapter is added to the public health accomplishments of the State Medical Society of Wisconsin. After years of effort to effect the passage of a law whose only purpose was

to protect the lives of the people of Wisconsin, the demands of a clear thinking profession are rewarded.


No.

WISCONSIN

State Board of Medical Examiners

HEREBY LICENSES

to practice Medicine and Surgery in the State of Wisconsin

In Witness Whereof said Wisconsin State Board of Medical Examiners has caused these presents to be signed by its President and countersigned by its Secretary at Madison Wisconsin and its official seal to be hereunto affixed this 1st day of [illegible] in the year [illegible]

M.D.

M.D.

1903—Resolution Urging Establishment of Tuberculosis Sanatoria Passed by Society

A pioneer in the campaign for the treatment and control of tuberculosis, Dr. T. L. Harrington, formerly of River Pines and now located in Milwaukee, introduced and urged the adoption of the resolution which initiated the movement for the establishment of tuberculosis sanatoria. The resolution provided in part as follows:

> "*Resolved,* That the Wisconsin State Medical Society cooperate with the smaller medical societies throughout the state for the dissemination of such knowledge and the establishment of sanatoria for the treatment of the consumptive poor."

1904—Colony For Epileptics Sought by Society

Stimulated by a scientific paper presented by Dr. W. A. Gordon, Winnebago, the Society directed the Committee on Public Policy of the Society to seek from the Wisconsin legislature the passage of a bill which would establish a colony for the epileptics in our state.

1904—Further Society Efforts to Establish Effective Tuberculosis Control

The committee appointed pursuant to the resolution introduced in 1903 reported that a bill which would have provided $100,000 for the building of a tuberculosis sanatorium was killed by the legislature. The recommendation was made that work continue and that the previous legislative proposal be modified to provide that the town or city of residence of the person to be hospitalized be required to pay "not to exceed one-half the actual expense of this maintenance at such sanatorium."

1904—Profession Opens Campaign of Public Education on Tuberculosis

The records of the Society disclose that the Medical Society of Milwaukee County had perfected arrangements for an exposition of several days' duration. Exhibits were prepared and displayed showing the deaths from tuberculosis, the incidence according to age groups and "the enormous financial loss to the community from and by reason of these deaths." So began in Wisconsin the long arduous task of continued public education through which tuberculosis was to be brought under control.

1908—Further Legislation Proposed to Aid in Stamping Out Tuberculosis

A resolution was introduced and adopted by the Society which requested that legislation be sought requesting the establishment of a bureau in Madison to make examinations of sputum and other secretions to determine if tuberculosis was present and to make reports to physicians as to its findings.

1913—Care of Alcoholics in Other Than Insane Hospital Sought by Dodge County Medical Society

The House of Delegates received from the Dodge County Medical Society a resolution urging that there be created a new institution for the care

of those addicted to chronic alcoholism. This resolution was referred to the Society's Committee on Public Policy and Legislation.

1915—Hospital For Inebriates Proposal "promptly chloroformed in committee"

The above terse caption is a direct quotation from the report of the Committee on Public Policy and Legislation to the 1915 House of Delegates of the Society. This follows the request filed by resolution at the previous session of the House of Delegates and a subsequent request made by the Medical Society of Milwaukee County.

1916—Postgraduate Medical Educational Program Obtained From the Legislature by Society

At the 1916 meeting of the House of Delegates a resolution was passed requesting the Regents of the University of Wisconsin to institute postgraduate medical instruction under the direction of the medical school of the university and the extension division. An appropriation of $5,000 was obtained from the legislature for this purpose a year later, which maintained a series of clinics in communities throughout Wisconsin for several years thereafter.

1916—First Committee on Social Insurance Appointed

Recognizing the importance of the subject, the president appointed a special committee to study compulsory health insurance and to make a report to the House of Delegates. The House ratified the appointment, provided the committee with funds, and urged that it keep the profession in the state as fully informed as possible on the subject.

1917—Profession Continues to Support Those Measures Giving Assurance of the Promotion of Public Health

Denial of Privilige to Dissect Threatens Study of Anatomy: A bill had been introduced the provisions of which would have stopped the study of human anatomy in Wisconsin. Wisconsin thereby would not have been able to train as capable physicians as in the past.

Tuberculosis: The Society assisted in the passage of bills which provided for the establishment of a sanatorium "north of the Central Line" and for one at Wales. Earlier efforts of the Society had been unsuccessful. The Society's efforts together with those of the Wisconsin Anti-Tuberculosis Association were, however, successful at this time.

Postgraduate Medical Education: The Society assisted in obtaining $5,000 for use in postgraduate medical education throughout the state. The program was to be conducted by the extension division and the medical school.

1919—Red Letter Year For Medical Education

By means of popular subscription and a gift from the Carnegie Institute a total endowment of $1,000,000 was created for "the medical school of Marquette University." During this same year the Board of Regents at the University made provision for the establishment of a complete medical course. Thus the effort of the Society, spread over a period of many years, resulted in attaining the public health goal established.

Marquette University School of Medicine.

Wisconsin General Hospital
University of Wisconsin Medical School

1920—Internship Asked of Legislature by Resolution Adopted by House of Delegates

To further elevate that standard of medical care afforded the people of Wisconsin a resolution was adopted by the Society at its meeting urging the legislature, "at its coming session, to make one year internship at a recognized hospital an obligatory qualification for candidates for license to practice medicine in this state."

1925—Wisconsin Physician Responsible For Creation of Council on Physical Therapy of the American Medical Association

One of the Society's delegates to the meeting of the American Medical Association introduced a resolution requesting that a committee be created and authorized to investigate scientifically and report on the value and merits of electrical devices, mechanical contrivances, colored lights, various kinds of lamps and similar appliances which were offered for sale to physicians and the public. The reports of this committee would afford the physicians and the public a reliable guide to protect them against fraudulent and unfounded claims by manufacturers.

1925—Wisconsin Leads the Way With the First Basic Science Law

The second introduction, at the request of the Society, in the Wisconsin legislature was successful in obtaining passage of the first basic science law. First introduced in the 1923 session of the legislature, but losing by a small margin of votes, the State Medical Society again blazed a trail of pioneer public health legislation by securing passage of the nation's first basic science law. By means of this measure the public is assured that those who profess to treat the sick must possess a basic knowledge in the subjects of anatomy, pathology, diagnosis and physiology. This public health effort of the Society stands as a symbol of the unswerving aim of the profession to seek out and promote those measures which protect the public from the incompetent who would attempt to treat them without basic knowledge.

[No. 27, A.]

ER_____ AWS OF 1925

An Act

To amend the title of chapter 147 of the statutes, to renumber sections 147.01 to 147.10, inclusive, to create sections 147.01 to 147.12, inclusive, relating to treating the sick and providing for examination and registration in the basic sciences, and to create section 20.435, appropriating the fees collected therefor

The people of the State of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1 The title of chapter 147 of the statutes is amended to read:

. . . *Treating The Sick.*

SECTION 2 Sections 147.01 to 147.10, inclusive, of the statutes, are respectively renumbered to be sections 147.13 to 147.22, inclusive

SECTION 3 Twelve new sections of the statutes are created, to be numbered and to read

147.01 (1) Definitions The "basic science law" is sections 147.01 to 147.12, inclusive, and as used therein

1927—To Make Motherhood Safer in Wisconsin

A resolution was introduced at the 1927 session of the House of Delegates of the Society urging the State

Board of Health and the Society to join forces in a study of maternal deaths and to "make a detailed and scientific study of all maternity deaths for a period of two or three years to determine as far as possible the underlying factors incident thereto and report the results of such study at a subsequent meeting of the State Medical Society."

1932—Society Favors Broadened Choice of Physician Under Workmen's Compensation Insurance

A special committee of the Society recommended that injured employees entitled to benefits under the Workmen's Compensation Act be given "free choice of physicians among all willing and capable." So began the movement which ultimately provided wide choice of physician through the adoption of the Open Panel Agreement between insurance companies and the Society.

1933—Elizabethan Poor Relief Laws Modernized in Part Through the Efforts of the State Medical Society

A committee of the Society caused a bill to be introduced in the Wisconsin legislature which would permit compensation to hospitals for the care of the indigent sick when prior authorization could not be obtained without a delay that might be injurious to the health and life of the patient. Thus the humanitarian purposes of the poor relief laws were not obstructed by the necessity of obtaining authorization before the seriously sick patient was hospitalized.

1934—Again the Society Urges Suitable Provision For the Care and Treatment of Epileptic Cases

Pursuing further action on earlier efforts to obtain proper care for the epileptics, the Society directed its legislative committee to urge upon the Board of Control and the legislature that provision be made for the care of these people.

1935—Medical Grievance Committee Established by Law at the Request of the State Medical Society

After having been unanimously endorsed for three consecutive years by the House of Delegates of the State Medical Society of Wisconsin, the Society caused to be introduced in the legislature a measure which would provide for the establishment of a medical grievance committee. This committee, by provision of the act, consists of the state health officer, the secretary of the State Board of Medical Examiners and the attorney general or the deputy attorney general. The committee is authorized by statute to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery in Wisconsin that are inimical to the public health.

1936–37—The Society Assists Governor's Citizens' Committee on Public Welfare

The report of the secretary discloses that during 1936 and the first three months of 1937, the secretary devoted much of his time to this public effort. During part of this period he served as acting chairman of the Subcommittee on Health and Disability. The entire facilities of the society were, at times, employed by the secretary to provide the subcommittee with accurate and reliable information, and assisted that committee in much of its research work.

The report of the subcommittee was immediately recognized as one of the most valuable studies and comprehensive surveys yet conducted of welfare and health conditions in Wisconsin. With the permission of Governor La Follette the report was printed by the State Medical Society and given wide distribution. Concerned with such subjects as those of insanity, mentally deficient, tuberculosis, crippled children, county nurses, medical and dental care of the indigent, and similar matters, the report immedi-

ately gained statewide attention. Various specific recommendations were offered, after a thorough factual statement had first been presented. Still of great value as reference material, the report stands as a monument to the untiring endeavors of the various committee members.

1937—Special Meeting of Society's House of Delegates Called to Consider Health Legislation

A special meeting of the House of Delegates was called to consider legislation which had been introduced in the assembly to provide for compulsory sickness insurance, unsupervised voluntary sickness insurance, group hospitalization plans and an interim committee to study the costs of medical care.

The House of Delegates opposed these measures after hearing the author of the bill explain them, and after giving extended and careful consideration to the provisions of each measure.

1937—Hall of Health Conducted by the Society

More than 100,000 Wisconsin citizens visited the Society's Hall of Health which was conducted in the Milwaukee Auditorium concurrently with the Ninety-Sixth Anniversary Meeting of the State Medical Society of Wisconsin.

Of great interest to those attending the Hall of Health was the transparent woman which was created by the staff of the Hygiene Museum in Dresden, Germany. The figure was constructed of a transparent material making every organ, even the delicately designed veins and circulatory system, clearly visible to the observer. Also of marked interest was the story of early human life (embryology). This consisted of a series of human embryos carefully selected to show advancing stages of development from a few weeks after conception to the time of birth. Other exhibits presented the history of roentgenography, the prevention of tuberculosis, the prevention and treatment of burns, cancer and a number of other health exhibits. A total of seventy-five booths were devoted to this public health education effort.

The transparent woman.

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Dr. James C. Sargent, Milwaukee, incoming president of the Society, in his address to the House of Delegates in September 1937, noted the period of economic and social emphasis, and the extent to which "the affairs of medicine and the care of the sick" had come under public notice. "During recent years, a wealth of interesting ideas have been coming to us from groups affiliated with medicine as well as from within the profession itself. These suggestions have been largely concerned with the broad subject of the costs of service to the sick and with methods intended, if possible, to lighten the economic burden involved," declared Dr. Sargent, who then stated his conviction that "a

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commanding group within the profession desires that we give the subject interested and honest consideration."

Following a detailed consideration of the president's recommendations, the House of Delegates authorized three separate studies in the field of health and general welfare, embracing the distribution of health service and sickness care in Wisconsin, European system of compulsory sickness insurance, and voluntary systems of hospital insurance.

Without question, the program embarked upon at this time by the State Medical Society of Wisconsin constituted the most comprehensive undertaking by any organization in the profession of medicine. Impartial, designed to be factual studies, carefully prepared and painstakingly compiled, the studies comprise an outstanding contribution in the field of the economics of medicine.

Space does not permit a complete recapitulation of the work of the Society in these three endeavors. The printed reports are still available, and reference to issues of *The Wisconsin Medical Journal* for the year 1938 and subsequent years indicates the extent to which this work has been relied upon by the Society.

For purposes of a summary of these activities, excerpts from the various reports are noted here that this epitomized record of the public health activities of the State Medical Society of Wisconsin may not lack completeness.

Distribution of Health Service and Sickness Care in Wisconsin

Committee personnel included: R. G. Arveson, M. D., chairman, Frederic; R. W. Blumenthal, M. D., Milwaukee; H. H. Christofferson, M. D., Colby; H. J. Gramling, M. D., Milwaukee; and J. Newton Sisk, Madison. The secretary of the Society, J. G. Crownhart, Madison, served as secretary to the committee.

"*The Charge of the Committee:* Your committee was created by this House a year ago to secure a more complete answer than previously existed to the following questions:

"(1) 'The adequacy of services presently available to our people.' Is the medical care offered the citizens of Wisconsin substandard in any respect or districts?

"(2) The availability of health services and sickness care to the citizens of Wisconsin.

"(3) The use of the services that exist for health purposes and sickness care in Wisconsin.

"(4) 'The tapping of the thoughts of those outside of the profession who have an informed and intelligent interest in these complicated problems,' and to report both factual findings and suggestions to this House.

"*The Technic of the Committee:* It should be borne in mind that for the fifteen months prior to April, 1937, our Society loaned the services of its secretary in substantially a full time capacity that he might be the acting chairman of the Subcommittee on Health and Disability of Governor La Follette's Citizens' Committee on Public Welfare. It is further to be kept in mind that this Citizens' Committee made a most comprehensive review of the field of the health and disability of our citizens; that the Society devoted several thousands of dollars to assisting the committee in its high purpose, and printed the report of the findings that it might be available immediately to members of the

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1937 legislature (then in session) and all citizen groups. It is important further to recall that our Society, particularly in recent years, has made continuous surveys of conditions within the state. By conferences and a large group of advisory committees, health problems have been reviewed continuously with state officials affected, public health authorities, and citizen groups generally. This procedure has resulted in a constant procession of accomplishments further promoting the public health.

"Our committee then was not faced with the necessity of gathering a large amount of basic statistical data since it was already available to it through the offices of this Society. The committee was aware of the fact that by the cooperation of all concerned, Wisconsin had gained the position of being one of the three healthiest states of the nation. The committee was aware of the ratio of hospital beds to population, the distribution of physicians, the public health policies of the state, the recommendations of the Citizens' Committee, and the statistical compilations that clearly mark one of the greatest conquests on the battlefront of disease prevention ever reported in a comparable length of time in any state or nation.

"The members of the committee had a natural pride in all of these accomplishments which they knew so well. In accepting the charge laid upon them, however, they felt that if they were to discharge their function they must put aside all thought of what had been done and proceed with a clear-cut assessment of the entire interrelationship of the citizens, the profession, and the state, and the services that were available, the services that were used, and the services that should have been available or used but were not. The committee held the conviction that nothing in the field of health was so sacred that it should not be examined with a critical eye and that it was under no obligation either to enshrine memories or to erect statues.

". . . visits to typical areas . . ."

"Your committee used the identical technic of the citizen-committee conference, which had been worked out so carefully by the leading sociologists and economists of the state for Governor La Follette's Citizens' Committee on Public Welfare, largely from a nonprofessional point of view. The picture is now completed by studies of this committee representing the medical profession. Your committee centered its attention upon visits to typical areas throughout the state. These areas were selected on the basis of being typical of other areas by reason of density of population, land use, employment, economic status of the population, problems of medical service arising out of physical or geographic conditions, and like factors. As a result of this representative cross-sectioning, the committee obtained and studied a picture of the state as a whole. After deciding upon the areas to be visited, the committee selected, after conference with local laymen and the medical profession, representatives of those citizen groups who were in position to relate to the committee the local experiences of a cross-section of population, and to leave with the committee their frank, constructive criticisms and suggestions. Invitations were then sent to these representative citizens, and the average conference between the responding citizenry and the committee covered an hour per person. Abstracts of the important points in these con-

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ferences were recorded in more than 800 typed pages that they might be available for our review and study.

"Thirteen counties of the state were visited, with all members of the committee present. Over 200 Wisconsin citizens met with the committee to discuss the health of our people. The conferences were marked by that utmost frankness which characterizes any genuine public effort to win still further conquests against disease.

"In addition, committee members individually held conferences with another 200 of our citizenry, and in separate sessions the entire committee had the advantage of conferences with over 300 representative members of the medical profession. Where rural areas were involved the committee members traveled by car and held informal roadside conferences with farmers, farm women, storekeepers, postmasters and garage men.

"Conferences were held in Douglas, Bayfield, Polk, Eau Claire, Marathon, Langlade, Brown, Sheboygan, Milwaukee, Racine, Dane, La Crosse, and Grant Counties. In addition, our studies comprehended conferences with citizens and the profession from the additional counties of Ashland, Oneida, St. Croix, Pepin, Chippewa, Burnett, Dunn, Rusk, Clark, Wood, Lincoln, Forest, Portage, Barron, Green Lake, Waushara, Kewaunee, Oconto, Shawano, Marinette, Outagamie, Manitowoc, Washington, Ozaukee, Kenosha, Walworth, Rock, Sauk, Richland, Crawford, Trempealeau, Jackson, Buffalo, Vernon, Monroe, Iowa and Lafayette.

"The counties that the committee studied by personal visit of the entire committee have a population of 1,386,041, or 47.3 per cent of the population of the state. When we add to this the population of the counties from which the committee had specific reports (1,024,666), we find the committee's work was in areas that represent a total of 2,410,707 of the 2,929,000 population of the state, or, in terms of percentage, 82.3 per cent of the total.

To Washington and New York

"The chairman of the committee and its secretary visited Washington, D. C. and New York City to hold conferences with the heads of official and nonofficial national organizations interested in public health questions. These conferences included such groups as those interested in medical cooperatives, the newly created Committee on Research in Medical Economics, the director of medical study for the Social Security Board, former members of the research staff of the Committee on Costs of Medical Care, former secretary of the health section of the League of Nations, medical director of the Rosenwald Foundation, and other officials of like organizations. The secretary of the committee secured government permission to attend the recent National Health Conference held in Washington, D. C., under the auspices of the Inter-Departmental Committee to Coordinate Health and Welfare Activities, and supplied the committee with all data there presented."

"*Organization Objectives:* Before Wisconsin was a State, the Territorial Legislature of 1841 granted the charter for the territorial society which subsequently became the State Medical Society of Wisconsin. Since its inception ninety-seven years ago, the Society has grown until it now comprehends a

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membership of over twenty-four hundred of the practicing physicians of Wisconsin.

"The principal objectives of this Society, like those of its constituent groups,—the county medical societies,—and those of its parent organization,—the American Medical Association, have been two-fold. The first objective has been to disseminate among its members knowledge of the progress of medicine, that each member might be equipped best to serve his patients, and the second, to bring the knowledge of medical science to bear in such ways as have promised to advance the health interests of the people of the state.

"The great accomplishments of American medicine have their roots in these organizations. Their high record of service, through long years of repeatedly demonstrated public accomplishment, has warranted in the past, and warrants in the future, the unswerving loyalty and unstinted support of every man and woman who by his action wishes to demonstrate that he is devoted to the fulfillment of those pledges that were assumed in taking the oath of Hippocrates. The doors of the home of the sick have ever opened to the physician because of the self discipline within the organization that has been the public guarantee of the integrity and high purpose of its vast membership. This can never cease if the self-imposed obligations of the group are to assure the citizenry in the future a 'racket-free' profession.

"The State Medical Society of Wisconsin initiated the legislation that resulted in creating the first state institutions for the care of the insane and feebleminded. Its proposals resulted in the creation of the State Board of Health, and laws instituting many of its present day duties and functions. Through the recommendations of this Society the legislature adopted the first enactments to protect the credulous sick from those who would prey upon them by fraud, deceit, and quackery. It was largely responsible for the beginning of medical education at our universities, many of the early tuberculosis sanatoria, and like institutions.

"Today the Society includes fifty-two component county societies holding regular scientific meetings. The State Medical Society has enlisted the cooperation of the University of Wisconsin to provide a medical library service, making available the most recent literature to physicians everywhere in the state. It cooperates with the State Board of Health and like institutions to provide within the state graduate training for physicians, and each year holds a three-day scientific session which attracts 1,500 of its members. Its radio and press messages on prevention of disease reach thousands each week.

Profession First to Suggest "Socialized" Medicine

"This statement is made that both the members of our Society and the public may know that the medical profession of Wisconsin does not by blanket terms condemn 'state' or 'socialized' medicine, for the records show that the profession itself was first to suggest it in those fields of health endeavor wherein it felt that the use of such methods promised most for the public health. There were forms of 'socialized' medicine in Wisconsin at the request of the State Medical Society before there was a Socialist Party.

"*The Practice of Medicine:* As is well pointed out in the report of our secretary of his studies and ob-

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servations in Europe, there can be no approach to a study of the distribution of either health service or sickness care without first having a keen understanding of the constituent parts of the practice of medicine. The House of Medicine has been built stone by stone, by successive generations of men who have devoted themselves to the welfare of their people. As stated by a physician who appeared before the committee,—'I am what I am because I stand on the shoulders of the men who have preceded me. I want so to live my life that those who follow me may stand on my shoulders.'

"Secondly, we must recall again that there is no sharp line of clear demarcation between what is sickness on the one hand, and good health on the other. Illness is not susceptible to a definition in law.

"Thirdly, there must be a thoroughly clear understanding that human beings have no identical set of reactions, even to the same disease, and even though that disease be of the same severity. Nothing is so individual as the reaction of a man to the forces of disease that work in his body. Further, we must reemphasize that while medicine is a science, its application in the case of the person who consults his family physician in ill health is an art. As has been pointed out, except for a comparatively few conditions, identical treatment for a given disease is nearly as rare as identical twins.

"The family physician of yesteryear may have lived in the saddlebag days of medicine so far as knowledge of the science of medicine today is concerned. But the family physician of one hundred years ago was a family physician because disease required individual treatment, and whether we wish it or not, disease will always require individual care and attention. The specialties with laboratory facilities, and the adding machine processes of medicine in some practices can never replace, and in the serious estimation of this committee never will replace, the attention, care, skill, family background and intimate and careful concern that belongs to the family physician. The committee wishes to emphasize that the family physician may disappear by name and title, but he can never disappear in fact if medicine is to perform for the citizens of this or any state the humanized and individualized service it is equipped to perform.

". . . duty of informing the public . . ."

"Finally, the committee is well aware of the fact that the physician represents one one-thousandth of the population of Wisconsin. In affairs of health in their broad public aspects, he has but one one-thousandth of the vote that determines, or may determine, that system under which our people are to receive their care in the future. But over and above this, he has the larger social responsibility of an individual whose life is dedicated to a profession. There lies upon every physician of this state, the obligation and duty of informing the public of the exact situation as it now exists and what in his estimation, based upon his knowledge and sound studies, may be anticipated for the public in any proposal of change.

"The accomplishments of the House of Medicine in both the science and art of healing—the two are indistinguishable—are now so clearly recognized by the public that it wants not only the facts and facilities, but assurance for the future health of Wisconsin citizens. They are entitled to know the facts as the

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profession in this state knows them, so that in the determination of public questions affecting the distribution of health service and sickness care the public decision may come from an informed citizenry."

Following this introductory statement, the report of the committee reviewed the availability of physicians in Wisconsin and the relationship of availability to the population needs of the state. The committee particularly noted that only in three specific instances were there areas in Wisconsin possessing a scattered population and poor transportation facilities in which a borderline need for more available services existed. In this connection the committee specifically recommended:

"The committee recommends that the Society urge upon the legislature an appropriation of $20,000 annually to be spent by the State Board of Health in supplying physicians to these and any other necessitous areas of the state, upon determination of the Board as to the areas in need. It is the committee's thought that such physicians might be subsidized as deputy health officers and by relatively modest sums be recompensed for the basic costs involved either in maintaining office hours within the necessitous area or, if found necessary, maintaining a home there. With the basic cost met it will be possible for the population to secure the physician's services on the same basis of cost as is involved for people in similar financial circumstances elsewhere in the state. The committee contemplates calling the attention of the legislature, however, to the fact that much of the population in such necessitous districts falls within the field of the medically indigent for whom the finances involved in at least serious emergency care and hospitalization might have to be met from a special state allotment."

Similarly careful studies and recommendations were made in the fields of hospitalization, preventive medicine, public health education, and certain public health procedures. In discussing the latter subject, the committee suggested that "the intent and effort of public health procedures is so well known to both the public and the profession" that no extensive factual findings appeared necessitated. But recommendations were offered in the fields of industrial hygiene, school house hygiene, maternal and child welfare, and other general problems. The committee called attention to a situation involving the state health officers, in such manner as to be deserving of special consideration here:

"For the fifth consecutive year the State Medical Society of Wisconsin calls attention to the fact that the health officers of Wisconsin are underpaid. Our State Health Officer, in charge of advancing the public health for nearly three million citizens receives but $5,000, and his ten deputy health officers are limited to $3,000, despite the fact that they are away from home almost continuously. Fully cognizant of the work that has been done by these men, the committee feels that the Society should point out to the public that if public health is to be advanced it is imperative to offer compensation that will attract to the state service the ablest men. We recommend that the Society again call this to the attention of the legislature, and that physicians throughout the State aid in that effort."

". . . costs of medical care . . ."

Following discussion of the subject of graduate education, the committee report embraced a comprehensive re-

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view of the subject of the costs of medical care, relating that subject to income groups, the public assistance group, and the marginal income group. The committee carefully analyzed the whole subject, pointing out certain basic considerations involved. The report states:

"In the discussions of the whole field of the cost of sickness care by the proponents of change, there has been the recurrent classification of the American people into 'income groups.' Thus, without definition, they refer to the 'indigent,' the 'well-to-do,' and the 'low income group.' The committee finds that there are too many factors entering into this situation to permit of such factually careless classification. Are we to say that a man sixty-five, receiving $1,200 a year as his sole income, is in a low income class? Is our answer the same whether that income is derived from his work as a watchman or whether it is derived from interest on savings that have a market value of $40,000? Is a man of twenty-five receiving an income of $1,300 to be classified as in a 'low income' group? (This is the Wisconsin average for employees of business and industry, and it is $8 above the national average.) Is our answer the same whether he is a single man with no dependents or whether he has a wife and two children? Is our answer the same if the wife has a small but independent income? Presumably if the population could be broken down into three or four income groups, the income tax authorities would have adopted this simplified procedure long ago. As a matter of fact, not even compulsory sickness insurance taxation departs from the income tax principle.

"Thus, the committee finds that individual, not group, consideration controls in the determination of ability to pay."

Summarizing its own findings in this respect, the committee states:

"Wisconsin's high rank in national health is plain indication that the people widely are receiving good medical service.

"Usefulness of procedures adding to patient costs are analyzed, with emphasis on limitation of those frequently used but not needed for good service except in individual cases.

"Where economic status justifies special consideration, physicians referring patients to consultants should so apprize them.

"The committee finds that citizens of the state cannot be classified into three or four main groups by income limits for purposes of furnishing sickness care, without grave injustice.

"In reviewing sickness care of those receiving public assistance, the committee recommends that more attention be given by the administrators to the humanitarian intent of the Wisconsin laws.

"The committee finds that there is a group in the Wisconsin population living at or below relief standards but maintaining independence. Budgeting methods of prepayment offer no solution to either the economic or health needs of these people, and have the added disadvantage of further reducing their standards of living, already too low. This group with marginal incomes deserves the redoubled efforts of the physician to fill its sickness needs, however small the amount of remuneration. This effort, the committee, knowing Wisconsin physicians, feels free to pledge.

"Your committee recommends that through interested county medical societies, further experiments in

providing medical service for people of limited means may be conducted. It recommends that in such experiments the profession should recognize and try plans that are proposed from groups within the public as well as any others that in the future we ourselves may deem deserving of trial. Restating, the committee feels that in further experiments, we should test the ideas that are brought to us as well as any further ones of our own."

In its concluding statement to the House of Delegates, the committee restated certain fundamental concepts of public responsibility that have guided all activities of the State Medical Society of Wisconsin since its organization over a century ago.

"Your committee feels that all our discussions, in the future as in the past, must be built around the one unswerving loyalty of the profession of medicine,—that to the sick man whose needs the profession exists to serve.

"Medicine will ill serve the public if it ever willingly agrees to sacrifice what it knows out of years of experience to be in the patients' interest in order either to avoid unjust charges or to promote a selfish end. There can be no criticism so lasting as the inner knowledge that the interests of the sick were sacrificed for profit or expediency.

"We must present the facts as we know them, to the limit of our abilities, and then, but only then, we must accept whatever conditions the public wishes to impose upon us, should they choose to submerge their health interests to others."

1938—Report of the Special Committee to Study Hospital Insurance

Created by the House of Delegates following the 1937 address of President James C. Sargent, the Special Committee to Study Hospital Insurance was appointed that fall and consisted of: Dr. Stanley J. Seeger, Milwaukee, Chairman; Dr. Stephen E. Gavin, Fond du Lac; Dr. R. G. Arveson, Frederic; Dr. E. L. Tharinger, Milwaukee; Dr. A. H. Heidner, West Bend; Sister Mary Bernadette, Supt., St. Mary's Hospital, Madison; Rev. Herman L. Fritschel, Supt., Milwaukee Hospital, Milwaukee; Mrs. C. D. Partridge, Secy., Wisconsin State Nurses Association, Cudahy; Mr. C. I. Wollan, Supt., La Crosse Lutheran Hospital, La Crosse; and Mr. J. G. Crownhart, secretary of the State Medical Society of Wisconsin.

The committee pursued a year-long study of the problem of hospital insurance, engaging as its counsel the Hon. Herman L. Ekern of Madison and Chicago. Reporting in the following fall to the House of Delegates, the special committee discussed the desirability of hospital insurance at length:

"Your committee reports that in its estimation there is a need for such insurance provided that:

"1. It is based on a sound financial structure, from an insurance viewpoint.

"2. Its operation be without either profit or unnecessary administrative cost at the expense of those served.

"3. It will assure now, and promote in the future, basic hospital facilities under conditions essential to good care for the sick.

"4. Its premium is the lowest possible consistent with sound hospital care and insurance practice so as to bring its budgetary advantages easily within the financial reach of all self-supporting citizens, particularly of low incomes, who desire to avail themselves thereof."

The committee particularly noted the demand that existed for such insurance, and its causative factors:

"There is in Wisconsin a definite demand for a plan of providing hos-

pital service to persons who now find it extremely difficult, if not impossible, to pay a hospital bill of more than a few days' duration. In Wisconsin the percentage of population that is supported on an annual cash income of less than $1,600 is over 85 per cent in all but five counties. The average annual cash income of the worker in industry and business in Wisconsin in 1937 was $1,360. This is a high average and does not include the farmer. This means there are many wage earners in the state who would benefit greatly from a hospital insurance plan when they or their families are forced to go to a hospital because of an accident or illness that is unforeseen.

"This conclusion is further borne out by the fact that in the United States in 1937, one person entered a hospital on the average of every 3.4 seconds, and the total patient days for the year was 344,719,140. Since so many persons normally are hospitalized each year—one out of every fourteen—and since sickness has its greatest incidence in the low income groups, it is an inescapable conclusion that hospital insurance is desirable and would be beneficial to the citizens of Wisconsin."

The committee particularly urged that the ultimate plan adopted should have a low cost feature "so as to bring it within the reach of the low income groups, and include as many as possible of those who have been accustomed to receiving free hospital service."

1938—Sickness Insurance in Europe

Possibly the most extensive study was that conducted by the secretary of the Society of sickness insurance systems in effect in Europe. Authorized as a part of the threefold study suggested by President Sargent, this first-hand study required an extensive preparation as well as a several month's first-hand survey. The report of the secretary was made to the House of Delegates in the fall of 1938, and shortly thereafter appeared in book form. It is not susceptible to brief condensation, yet certain of the secretary's observations* should appear here:

"It was Dante who said 'give light and the people will find the way.' His expression of the democratic way of life today, as never before, needs to be applied to this proposal so often labeled as one for 'health insurance.'

"The Brilliant Idea"

"Regardless of what country is visited and regardless of wide variations in wordings of specific laws, at the end of the study one is deeply impressed that certain principles are found in operation wherever this law is enacted, and these are inherent to the legislation and not susceptible to elimination through amendatory legislation.

"Like all compulsory social insurance, compulsory sickness insurance is financed by compulsory pay check deductions, together with a pay roll tax paid by the employer and added to the cost of his commodity or service price, and sometimes aided by a state or federal appropriation. Where state or federal aids are a portion of the finances of the system they tend to decrease, over a period of years, in either amount or proportion until relatively they are insignificant as a source of financial support.

Two Separate Functions

"Thus compulsory sickness insurance legislation normally comprehends two separate functions: (a) provision for caring for the sick-

* Excerpts from an address presented before the Health and Accident Underwriters Conference, Chicago, June 3, 1941.

ness needs of the covered person and generally of his dependents, and (b) a wage loss compensation to cover periods of loss during illness of the wage earner. Substantially all systems place a limit of twenty-six weeks on the benefit period and establish a waiting period of three days or more before cash wage loss benefits begin. Because in an insurance system so large in its coverage, numbers of individuals will have disabling illness beyond a twenty-six weeks' period, practically all systems have as an integral part, or as accompanying legislation, an insurance for invalidity. This invalidity insurance, for a smaller premium, attempts to cover the sickness care required for the illness that extends beyond the twenty-six weeks' period covered by sickness insurance proper.

"Furthermore, it should be clearly understood at the outset that compulsory sickness insurance in the United States could at its best cover only those who are employed on wages or salary. Under all proposals made to date that we have examined, substantially the entire farm population has been excluded for unless the system is federally operated through the sale of tax stamps by each post office and rural carrier, it becomes far too expensive to endeavor to make tax collections in any other way than by the employer of the groups acting in that capacity for the government. The further difficulty in estimating the income of large groups of our rural population in terms of exact dollars upon which the tax can be levied is a further barrier so that when we speak of compulsory sickness insurance as it would actually exist in the United States, we must not think of it as a system whose benefits, whatever they may be, would to any considerable extent reach beyond the wage and salary earner in our population. This is a large percentage in many states, but is very far from a universal coverage system, excluding as it must, not only the farmer but the individual entrepreneur, the domestic servant, the unemployed, those on relief, the aged, and numerous other classes.

Unlike Other Insurances

"Sickness insurance differs vastly from all other social insurances. Unlike our existing social security legislation for unemployment insurance, old age assistance, old age retirement benefits, aid for dependent children (mother's pension), and aid to the blind, compulsory sickness insurance does not pay out all its benefits in cash with which the beneficiaries may purchase the necessaries of and to life. Like the workmen's compensation acts, the benefits provide for a cash payment to cover a portion of wage loss and a medical benefit.

"Secondly, it is to be noted that unlike all other social insurances, in compulsory sickness insurance the event insured against, to a large degree, is within the control of the insured person. We can define unemployment in a law; it is an event that no one wishes to have happen. We can define the conditions precedent for the benefits of old age assistance in terms of both age and limited property ownership. But how can we define illness when it may be of such varying degree, dependent upon so many different factors, and at times actually constitute a welcome temporary or even a more lasting haven or refuge, which of itself may be a form of illness? If the state of good health could be defined, then we would have a basis upon which to say that a deviation constituted

sickness,—the event insurance covered. Actually no such definition can be made. One of the marvels to science, on the one hand, is the individual who may deviate greatly from the principles of right living and yet not be aware of ill health, and on the other hand, the 'frail' person who outlives all presumably robust members of his family.

"Furthermore, there is a constant conflict, always reflected in premium inadequacies, between the administration of compulsory sickness insurance as a protection against an undesired occurrence of a hazard of life, and on the other hand, as a social insurance wherein the greater the usage made of its benefits, the greater presumed health benefits to the nation will be had. The end result is an insured population that thinks of this legislation as constituting the payment for a social health service to be placed in immediate use if possible, while the administrator is faced with supplying benefits computed on an insurance concept.

Limit on Wage Deductions

"Again, from the viewpoint of insurance, how may we establish an adequate premium without depriving those in the lower wage brackets from the necessaries of life upon which sound health itself is predicated? How, at the same time by this self-limited premium, may we raise funds sufficient to pay the costs of a partial wage loss and every needed sickness care for all types of illnesses that may be experienced? Unfortunately under compulsory sickness insurance the premium is established in the initial enabling legislation. And, unlike premiums for the voluntary cash insurance, the premium for compulsory insurance may be increased only in theory. I pointed to one reason in the statement that there was a practical limit to how much could be subtracted from pay checks on the one hand, and added to commodity prices by pay roll taxes on the other hand.

The Man Who Pays

"The recipient of benefits under compulsory sickness insurance knows exactly what he is going to receive in terms of cash for his wage loss benefits when these are a part of the system as is so universally the case. This is not the case of his medical *service* benefits. To the extent that the amount of money required to pay wage loss has been underestimated in establishing the initial premium, to that same extent must the sickness insurance fund divert money from sickness care to defray wage loss claims.

"The physician becomes the actual insurer of service, for the administrator turns to him and says, in effect, 'Henceforth this system of compulsory sickness insurance will supply the medical care that large numbers of patients formerly received from you. Do you wish to be a part of this system?'

"Obviously, numbers of physicians, and particularly those who live in the industrial areas, can ill afford to say, 'No,' to such a question. And it is then that they become the real insurers for the system says to the physicians, 'Very well, then, for each person that we cover who chooses you as his family physician when he enters the system, we will pay you so many dollars per year.' For this flat amount ($2.25 per year per individual in the English system, for instance) the physician undertakes to render the care that the terms of the law provide he shall render.

1938—Sickness Insurance in Europe

Rules For the Patient

"Note, incidentally, that the covered person who becomes ill does not call his physician tonight on the basis of his particular illness needs. He must make his selection when he becomes insured. His selection must be from those physicians who live close to him. If the income of the service permits any specialist service, which is always contemplated but rarely exists, he may go to the specialist solely by reference and then only when the rules and regulations permit. Does he wish to change his physician? Then he must wait until the next change-over period. Nor may he change for reasons that are deemed to be frivolous.

"This is not a system which supplies the cash with which the patient may secure his own sickness needs under contracts into which he himself enters. There are rules for patients and the first one deprives him of choosing his physician at the time of his illness.

Rules For the Physician

"And then there are rules for the physician, too. For despite the fact that the system has used the physician as a reinsurer, what the physician prescribes and what he tells the patient to do cost the system money, and this expenditure can be controlled only by controlling the physician. Not only does such control exist, but it is tightened from time to time as the financial exigencies indicate, or in fact, may require.

"Every system has rules and regulations for the physician,—frequently published in the form of a little pamphlet. Here are the treatments he may use; here are the drugs he may prescribe; here are the amounts of drugs he may prescribe; and here are the exact forms in which he may prescribe them. Here is the 'book' within which he must stay.

"Sickness Licensing System"

"When I was in England, there had just been issued after a long period of study an exhaustive report on the British health services by one of the leading economic institutes of the land. In commenting on this exact point, this report declared, 'Excessive numbers of panel patients and excessive demands for certificates and returns of all kinds quickly reduce the general practitioner to an agent for making out prescriptions (too often for mere palliatives), and for operating something more like a sickness licensing and registration system than a health service.' Is it any wonder that Rubinow pointed to the fact that the term 'health insurance' was a politician's subtle way of selling a wrapped package?

"The whole thought of early service as a means of health security is inevitably lost. The theory and social service concept of the law is replaced by the cold, hard, actuarial experience, the operation of which always comes as such a shock to one who looks upon insurance as a source of a gift rather than as a means to a service, the actual extent of which depends solely upon coverage and actuarial computations.

" 'Oh,' says the proponent of 'health insurance,' 'if we but had this plan in operation the physician who is waiting for patients, and the patients who have need for the physician, would be brought together.' Now, may I assure you first of all that where choice of physician exists, the busy physician becomes the busier physician. The physician less busy and because of this having lower fees, under such a system

has even less to do for with the removal of the fee differential, patients go to the physicians of the greatest prominence within the realm of choice.

"And next, proponents of compulsory sickness insurance say to you that with removal of the so-called economic barrier between the patient and health, he can at last secure adequate and timely service. Unfortunately, this patient finds himself facing the barrier of rules and regulations; the barrier of a physician too busy 'licensing his patients' as the English put it, to have time to give the adequate care that the social service concept visualized. The patient finds the physician himself governed by rules and regulations. The patient finds a physician, who, if he goes outside the costs of treatment laid down by the rules, will face a pay check deduction of his own come the next quarterly pay day. And so the physician tends more and more to stay inside his book of instructions; to accept the legislation for what it is, recognizing eventually the futility of attempting to repeal it; recognizing that if he is critical of the system, he will not long remain a part of it; recognizing, as so many physicians put it abroad, that 'we must do the best we can and get on with it.' An assumed barrier has been exchanged for very realistic ones.

"As one studies at firsthand not the wording of laws but their actual operation, one is more and more impressed that the administrator, out of necessity, becomes the trustee of funds and with each succeeding year the concept of guardianship of health fades still further into a hazy background.

"Principle of Economy"

"Throughout the entire history of compulsory sickness insurance runs the central theme of the administrator,—the operation of 'the principle of economy in health benefits.' These words are the exact title of a publication by the International Labour Office,—its last major publication in this field before the present war.

"The observer and student of experience abroad will not be quick to criticize what foreign governments have done to ameliorate conditions to some extent for populations of poor people, conditions that have never existed in this country. But the same observer seeking a framework upon which further to build for the continued health advance of our people comes back deeply impressed that the difficulties that I have here mentioned today, and others on which I have had no time to dwell, are inherent in the operation of compulsory sickness insurance laws.

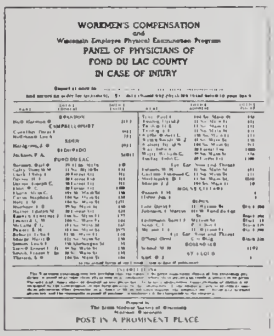
The Real Purchase Price

"I would leave you with the thought, not that we cannot have compulsory sickness insurance here or that its closely-knit proponents are not making headway to that end. I would leave you with my own conviction that such systems have their own diseases that are of such consequence that they can be classed in the same breath with heart disease and cancer; that these, rather than the money contributions, constitute the real purchase price of this so-called social legislation."

1938—The Society Makes It Possible For the Injured Workman to Have Wide Latitude in Choosing His Physician

Following the action taken by the 1932 House of Delegates, studies were made and conferences held to make it possible for injured workmen to be given "free choice of physician among all willing and capable." In 1938 the Society announced the Open Panel

Agreement. This agreement was entered into by the Society and virtually all insurance companies writing compensation insurance in Wisconsin. The Society, on the basis of this agreement, prepared and distributed to all Wisconsin employers subject to the workmen's compensation act printed panels of physicians for each county in the state. Employers were urged by both the Society and the Wisconsin Industrial Commission to post this panel in a prominent place where employees might see it and exercise a choice in the selection of their attending physicians when they were injured in the course of employment.


WORKMEN'S COMPENSATION
and
Wisconsin Employee Physical Examination Program
PANEL OF PHYSICIANS OF
FOND DU LAC COUNTY
IN CASE OF INJURY

POST IN A PROMINENT PLACE

An Open Panel.

1938–1941—State Medical Society Experiments in Voluntary Sickness Insurance

Three actual plans for voluntary sickness insurance were conducted by the State Medical Society from 1938 to 1941. These plans were conducted in Superior, Milwaukee (Greendale) and Rock County.

It was possible for the Society to conduct these plans under its own statutory charter law to which the Society had obtained an amendment in 1935. The experimentation was further made possible by the actions taken by the Society's House of Delegates in 1938 when it adopted the report of the Special Committee to Study the Distribution of Health Service and Sickness Care in Wisconsin.

Over a period of many years the Society has studied and investigated plans of voluntary sickness insurance and has been cognizant of the many inherent public dangers invariably found in those plans. That these dangers might be held to a minimum in the profession's research studies, the Society adopted a series of eleven basic principles or safeguards under which its own trial plans would operate.* Of paramount importance was the concern that the patients under the trials would not receive a deliberately cheapened service due to an insufficient premium. The research technic employed by physicians in studying diseases was applied to this series of social experiments. One of the eleven principles which the Society adopted provided that each experiment should incorporate basically different principles and that there should be no duplication of experiment. Other principles incorporated were the free choice of physician, the plans to be applied initially in local areas, the quality of the service must be unchanged even if premiums proved grossly inadequate, the experimentation should not be motivated by profit to the physician, the terms of the plan and the service to be given must be clear and unmistakable to the people served, and no profit was to accrue to any promoter or promoters of a plan.

The Society had declared that it stood ready to subject to trial plans suggested either by the profession or the public. A plan designed by the public was put to trial in Superior. It was conceived and operated by the Cooperative Health Association and conformed to the safeguards established by the Society. Prior to actual operation, marked efforts had been made in the community to interest the public in such a plan. A full time manager was employed by the cooperative group, and for a period of six months, efforts of the manager and the directors of the association were consumed in an attempt to enroll sufficient subscrib-

* Contained in full in the 1938 report of the Special Committee to Study the Distribution of Health Service and Sickness Care in Wisconsin.

1938–1941—State Medical Society Experiments in Voluntary Sickness Insurance

ers to begin operation of the plan. Finally, after six months of effort, slightly less than the established minimum of 150 subscribers was enrolled. The plan, however, was placed in operation on July 1, 1939. The plan operated for a period of eighteen months, during which period intensive enrollment efforts were sustained to obtain additional subscribers. The plan did not enjoy public acceptance, and insufficient numbers were enrolled to pay the operating costs. If it had not been for the Society's contribution to its administrative fund, the premiums established by the cooperative group would have paid approximately 50 per cent of the physician's statements submitted to the association for services rendered subscribers, which were based on the minimum charges made by physicians in the community. After two years of a series of intensive campaigns for the enrollment of subscribers, only 295 subscribers were enrolled in the plan. In addition to the insufficiency of premiums which were established by the Cooperative Health Association, some of the other considerations which caused the Douglas County Medical Society to discontinue its cooperation were the extremely high cost of obtaining subscribers (sales), the failure of the plan to reach the so-called low income wage earners, the operating costs were too high when this new "middle man" was added to the cost of medical care, and finally, the premium structure did not permit the payment of minimum normal fees and leave funds for the creation of a reserve.

A second plan incorporating basically different features from those incorporated in the plan of the Cooperative Health Association was conducted at Greendale, Milwaukee County. This plan was conducted by the Medical Society of Milwaukee County, and here was subjected to trial the so-called deductible type of insurance. The subscriber under the plan was required to pay the first $24 of medical care needed by the family during the year. Thereafter the subscriber and his family became eligible for an unlimited amount of medical and surgical care from any one of over 450 Milwaukee physicians who had agreed to participate in the plan. The second distinguishing feature was that the subscribers were selected on a group basis, as distinguished from the physical examination method of selection which was employed in the Superior trial.

Every home in the community of Greendale was covered in a house to house canvass. After several months of effort the minimum of 200 subscribers was reached. The plan operated for the full period of the contract year even though the citizens' committee at Greendale was unable to maintain the minimum number of subscribers established under the agreement.

The premiums established made possible the payment of but 36 per cent of the customary charge for the services which were rendered under the plan. This same plan was offered to a second government housing project at Park Lawn. Here, the voluntary committee failed in spite of an arduous campaign to obtain the required one-third of the eligible subscribers in the community, and the plan was not placed in operation. It was also offered to a number of individual concerns and to the unions in Milwaukee. No indication was given by any of these latter groups that they desired to avail themselves of this insurance.

A third trial plan was placed in operation in Rock County. This plan was designed to reach small groups on a group selection basis and to provide them with unlimited medical care without the deductible feature.

1938–1941—State Medical Society Experiments in Voluntary Sickness Insurance

Individual efforts were made by the members of the Rock County Medical Society to interest employers and employees in the plan, and the Society itself held a series of dinner conferences to which were invited a large number of employee representatives, both in Janesville and Beloit, to explain the plan and to attempt to interest them in it. In spite of these efforts they were unable to enroll the required minimum number (150 subscribers).

A fourth plan was offered to the Farm Security Administration under the terms of which they would become the guarantor of the payment of the services if the premiums were inadequate to pay even the markedly reduced schedule of fees provided under the plan. This agency indicated that it would be impossible for them to accept this responsibility. The committee has submitted a further plan to the Farm Security Administration and currently has before it a proposal to provide a limited type of surgical insurance for employed groups. The committee has designed and discarded a number of plans. This community effort by the Society is a continuous one with the goal ever before it to evolve a plan that will, in fact, be a contribution to the advancement of public health in Wisconsin and one which holds within it a minimum of public health danger.

Among the more significant findings reported by the Society's Committee was the conclusion that limited experimentation had been a wise procedure rather than to embark upon a widespread plan before an opportunity had been had to examine critically the operation of what might be termed laboratory experiments. The committee also concluded that, (1) The experience obtained in Wisconsin, as well as that reported in other states, that there had been little, if any, spontaneous demand by the people for the prepaid medical care plans. (2) The physical examination procedure of selecting subscribers was not the method of choice. It appeared on their limited trial efforts, and experience elsewhere, that the group selection method was more satisfactory. (3) Subscribers under voluntary sickness insurance did not request preventive procedures in any appreciable amount even though the cost of this service had been paid in advance. (4) Free choice of physician is actually and ardently desired by the public. (5) The plan of subletting to other organizations, corporations or associations the sales effort involved in obtaining subscribers contained many inherent dangers which at that time did not seem possible of elimination. (6) There should not be a large number of individually established and operated sickness insurance plans. (7) Should a plan of voluntary sickness insurance be found which would be subject to wide application, it should be operated on a statewide basis.

Finally, it was found by the committee that Wisconsin citizens, as represented by the subscribers who had participated under the plans, are now receiving the needed medical care. An exceedingly high percentage of those applying for participation in the plans stated that they did not have any known medical needs.

* * *

Thus ends a brief chronicle of the first one hundred years of formally organized medicine in Wisconsin. The pages of history in the future will measure the work of the present, as the present measures the accomplishments of the past. But in all can be found and always will be found that indefinable thread of the devotion of medicine to the cause of good health and the amelioration of suffering and pain—to the eternal good of mankind.

. . . . THE PRESIDENT'S PAGE . . . .

Tradition of Service

THE State Medical Society of Wisconsin, as it has developed over the years, has built traditions that distinguish it among those organizations devoted to the advancement of the science and art of medicine, and the promotion of patient health. This issue of *The Wisconsin Medical Journal* is but one of the traditional services of your Society.

In 1928, the Blue Book was first visualized by our secretary's office, and at that time, and again in 1929, the material, much of which was in the character of that appearing in this issue, was printed as a special volume distributed to all members. The many demands upon the profession and the Society in the years of the depression caused its temporary abandonment as a separate issue, but the tradition continued as article after article appearing in the monthly pages of the *Journal* were devoted to clarifying procedures, regulations and rulings with which the medical profession comes in contact as it serves the public interest. A few years ago the Blue Book was reinstated. It became an annual edition as one of the numbers of the *Journal.* It has been tempered to the needs of the times. It has been designed always as an instrument of inestimable aid to the physician.

This issue of the Blue Book, in keeping with that tradition, marks a further effort of the Society to compile material of particular value. Where once the subject of poor relief administration entered so prominently into the field of the delivery of medical care, there now appears material relating to the physician in his wartime services to the country. A general outline of outstanding events in the history of the Society has been prepared as a basic necessity in reacquainting the members of the medical profession with the fundamentals of medical organization. In the years that lie ahead, this basic outline will be gradually expanded so that in time the work of the State Medical Society of Wisconsin, particularly during those outstanding years when various economic studies were undertaken, may be reviewed and summarized in valuable detail.

To a profession that is busy beyond measure, I commend the careful scanning of this Blue Book edition. Keep it on your desk for ready reference. Use it frequently. It is one of the most valuable publications of your Society.

F E Beitler

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Income Tax Provisions Affecting the Medical Profession

Acknowledgment is made of the courtesy of both federal and state tax officials in reading this material and in making suggestions, all of which have been incorporated. Wherever references are made to form numbers or to general requirements below, it is on the basis that the tax officials anticipate that such forms or such requirements will continue unchanged.

I. FEDERAL

1942 Amendments

THE 1942 Federal Revenue Act, which became law on October 21, is the most far-reaching income tax law in American history. It is, first of all, retroactive in the sense that its provisions and rates apply to all individuals whose income tax year began after December 31, 1941, where such individuals are on a calendar year basis. In the case of a taxpayer whose tax year ended some time between June 30, 1942, and December 31, 1942, in other words one who is on a fiscal rather than a calendar year basis, there is a different rule applicable. A 1942 amendment provides that in such cases the income tax shall be computed on the basis of the 1941 rates prorated for the number of days in the taxable year of the individual which occurred before July 1, 1942, plus the tax due computed on the basis of the 1942 returns prorated for that number of days in such taxpayer's tax year which occurred subsequent to June 30, 1942.

Examples: (1) Prior to January 1, 1942, a physician was on a fiscal year income tax basis ending September 30. His 1942 income tax return should first be computed on the basis of 1941 rates. The result should be multiplied by the fraction 273/365, since 273 days of his taxable year had expired as of June 30, 1942. The taxable income should then be computed on the basis of 1942 rates and this result multiplied by the fraction 92/365, 92 days being the portion of the taxable year remaining after June 30, 1942. The second result should be added to the first result and the sum will be the tax due.

(2) A physician was granted permission subsequent to January 1, 1942, to change from a calendar year to a fiscal year basis ending September 30. During 1942 the tax year would have only nine months, or 273 days in this particular instance. Of these 273 days 181 expired between January 1 and June 30, 1942. After net taxable income has been determined the 1941 rate should be applied, and 181/273 of that tax will be payable for the year 1942, plus 92/273 of the tax computed at 1942 rates.

The individual rates, including the surtax, begin at 19 per cent instead of at 10 per cent, as in 1942, and are sharply graduated upward. It is estimated that the 1942 amendments will subject to income tax for the first time some 30,000,000 wage earners and others who have heretofore been exempt.

Three points should be made at the outset of this article: First, nearly all physicians in full time practice, barring those whose salary or other income is nominal, will be directly affected by the 1942 federal act. No longer is the federal income tax one which touches only those in the higher brackets as is shown in Table 1 on the following page. Second, it was never before so essential for the physician, in common with other taxpayers, to keep complete records of his professional income and expenses, together with complete records of his personal investments and of the income and expenses incidental to them. Third, excluding the simple case in which a physician's sole income is derived from his professional salary, with no dependents and no investment transactions to complicate the picture, it is strongly urged that the physician not attempt to make his way alone through the tax maze. The advice of an attorney, or of a qualified tax accountant, on questions of dependents, professional expenses, capital gains and losses will more than repay the immediate cost of such services, besides minimizing the possibility of assessment of additional taxes at some future date, with attendant loss of time, expense and worry.

It is suggested that the physician take this article to his attorney or accountant because its emphasis and content are directed to the special problems of physicians, and it may prove a saving both in time and expense to give such consultant the assistance which this article can offer in the light of its specific emphasis.

Federal Tax Prospects

While it is obviously impossible to prophesy with any assurance the course of federal taxation in the years immediately ahead, two statements seem warranted by all present indications. The first is that tax rates on individuals will rise substantially higher, especially for those in brackets under $15,000. The second is that allowable deductions from gross income will be fewer, thereby raising the tax of the individual still higher.

There are eminent tax authorities who anticipate, for example, the elimination, perhaps in 1943, of the joint return by husband and wife which is frequently used to tax advantage by a person having a substantial income whose spouse has suffered losses during the same tax year. Still another change anticipated in some quarters is the elimination of provisions dealing with capital gains and losses. While this change may be welcomed by those making a gain from investments, it will prove a heavy additional burden to that large number of taxpayers who have not yet been able to dispose at any price of property or securities which, whenever sold, will show a heavy loss.

TABLE 1.—*Total Tax Increase on Individuals Under Revenue Act of 1942*

Assuming Married Person, All Earned Income, No Dependents

Net Income[1]	1941 Law	1942 Law[2]	Increase in Dollars[2]
$1,500		$ 48.00	$ 48.00
2,000	$ 42.00	140.00	98.00
2,500	90.00	232.00	142.00
3,000	138.00	324.00	186.00
4,000	249.00	532.00	283.00
5,000	375.00	746.00	371.00
6,000	521.00	992.00	471.00
7,000	687.00	1,246.00	559.00
8,000	873.00	1,532.00	659.00
9,000	1,079.00	1,826.00	747.00
10,000	1,305.00	2,152.00	847.00
15,000	2,739.00	4,052.00	1,313.00
20,000	4,614.00	6,452.00	1,838.00
25,000	6,864.00	9,220.00	2,356.00

[1] Figures in this column represent net income before deducting personal exemption.

[2] Does not include Victory tax which, except for amounts withheld from wages and salaries, is not payable until the return of 1943 income is filed (in the case of a calendar year taxpayer) on March 15, 1944.

Tax Savings Notes

The Treasury Department, so as to make it easier for the taxpayers to meet the heavily increased taxes required by the national defense program, is offering for sale two series of notes which are available at all local banks. The Series A notes are especially designed for the smaller taxpayer, and if held long enough pay slightly less than 2 per cent. No taxpayer may use more than $1,200 par value of these notes in payment of income taxes in any one tax year. Series B notes, which are designed for larger taxpayers, pay about one half of 1 per cent interest, and are unlimited as to the amount which may be presented in payment of income taxes in any one tax year. These tax savings notes are not transferrable, cannot be used as collateral, and the income from them is taxable by the Federal Government. Series A notes can be redeemed at any time at the price paid without advance notice. Series B can be redeemed at the price paid at any time after sixty days from the time of issuance to the taxpayer upon thirty days' notice.

It was never before so essential for physicians to acquire the habit either of purchasing tax savings notes or of making corresponding savings in some other way so as to be prepared for the tax liability each year.

General Instructions

Returns for all taxpayers reporting on a calendar year basis must be made to the Collector of Internal Revenue of the district in which the individual affected resides, before March 15, 1943, at which time the tax is due and payable. In the event the taxpayer desires to pay his tax on the installment basis, the first installment of one quarter of the tax is due on March 15, 1943, and a quarterly installment every three months thereafter; namely, June 15, September 15 and December 15. An extension of the time for filing a return can be had for reasonable cause. Application for extension should be filed with the Collector of Internal Revenue in the district in which the applicant resides. Such application should be made before March 15 under oath on Form 1134, copies of which may be obtained from the Collector of Internal Revenue at Milwaukee.

Responsibility for making these returns is vested in the individual. As will be noted from reading the paragraphs following, liability to make a return depends not on whether one has a tax to pay, but on the amount of his reportable income.

Tax Returns

There are important changes in the rules prescribing the form of return to be used for 1942 incomes. The large Form 1040 *must* be used by all taxpayers whose gross income exceeds $3,000, or is derived from a business, or from any other sources except the following: Salary, wages, compensation for personal services, dividends, interest, or annuities. Where the gross income from any of the above sources, on a cash and calendar year basis, is $3,000 or less, the 1942 Revenue Act permits the taxpayer the option of making his return on the large Form 1040, and of showing his full expenses, depreciation and similar deductions thereon, or of using Form 1040A, and paying a fixed income tax in the latter case. See also fuller discussions of the subject under "Optional Tax on Gross Incomes of $3,000 or Less," page 63.

The large Form 1040 will ordinarily be mailed to all Wisconsin physicians by the Collector of Internal Revenue. If not received by the first of February, apply to the Collector of Internal Revenue at Milwaukee or Madison, since the burden is on the physician to obtain and make the return whether a form is sent him or not.

Every married person, living with husband or wife, having a *gross* income of $1,200 or over, and every husband and wife, who live together and have an aggregate *gross* income of $1,200 or over, must file separate returns, or a joint return, regardless of the amounts of their joint or individual *net* incomes. Every single person and every married person not living with husband or wife, having a *gross* income of $500 or over must also file a return irrespective of his individual *net* income.

Liability of Physician in Service

Strictly speaking, a physician serving in the armed forces of the United States is liable to make an income return just as though he were still in civil life. In many cases the physician's wife or attorney-in-fact can and will make the return for him. Where no such arrangements have been made, and the physician is outside the country until after March 15, 1943, it will not be possible as a practical matter for him to make a return within the time required by law. Although the authorities have not thus far granted a blanket excuse or extension for

filing in such cases, this will undoubtedly be done in practice.

As to the moratorium on federal income taxes in the case of physicians in service, see treatment of the point on page 168 of this issue, in the article entitled "The Amended Soldiers' and Sailors' Civil Relief Act."

Tax Rates

The *normal* tax rate for the calendar year 1942 is 6 per cent on the *net* income in excess of exemptions, credits for dependents, earned income credit, and credit on the obligations of the United States and its instrumentalities. *Surtaxes* have been subjected to a steep rise in rates in all brackets, the initial rate having risen from 6 to 13 per cent. "Surtax net income" is defined under "Determination of Income," this page. The increase in tax rates is so marked that it will constitute a major item in the budget of the majority of physicians and will become the largest single item for some.

If the marital status of a taxpayer changes during the taxable year, the personal exemption shall be an amount which bears the same ratio to $500 as the number of months during which the taxpayer was single bears to twelve months, plus an amount which bears the same ratio to $1,200 as the number of months which the taxpayer was married and living with husband or wife or was the head of a family bears to twelve months. For this purpose a fractional part of a month shall be disregarded unless it amounts to more than half a month, in which case it shall be considered as a full month. Changes in the credit for dependents allowed a taxpayer are apportioned in like manner. This rule of apportionment as to marital status by their dependency is not applicable to a taxpayer for a gross income of $3,000 or less who elects to make returns under Supplement T of the 1941 act on Form 1040A. See "Optional Tax on Gross Incomes of $3,000 or Less," page 63.

Earned Income Credit

A credit against net income, for the purpose of the *normal tax* only, is allowed by the 1942 law, calculated at 10 per cent of the earned net income. All net income up to $3,000 is considered to be earned net income regardless of its source, and the maximum earned net income that may be considered is $14,000. Thus the maximum earned income credit allowable against net income for the purposes of the normal tax is 10 per cent of $14,000 or $1,400.

Earned net income is defined as the excess of the amount of earned income over the sum of deductions and expenses properly chargeable against or allocable to the earned income. Under the statute earned income means "wages, salaries, professional fees, and other amounts received as compensation for personal services actually rendered." In a professional occupation the taxpayer may include as earned income all professional fees even though assistants perform the services, provided the clients are those of the taxpayer.

Determination of Income

The term *gross* income as applied to a physician includes the total compensation received by him during the taxable year for professional services, including receipts from the sale of spectacles, in whatever forms such compensation may be paid, including compensation paid by a state, plus the amount received in interest, rent, dividends, securities, or from the transaction of any business conducted by such physician, or the sale of any capital assets.

The term *net* income as applied to a physician means the *gross* income computed under the above definition less allowable deductions for professional expenses. The *net* income subject to the *normal* tax is further reduced by the taxpayer's personal exemption, credit for dependents, earned income credit and interest on obligations of the United States and its instrumentalities.

The term *deduction* as applied to a physician means any amount allowable as a professional expense. Various classes of deductions are treated in detail below, beginning at page 64.

The terms *personal exemption* and *credit for dependents* have reference to the amounts allowed because of one's marital status or family obligations. These matters are treated in full detail in the instruction sheet attached to the return, and are also considered under "Personal Exemptions and Credits for Dependents," page 62.

"Surtax net income" means "net income" as above defined, as further reduced by the personal exemption and credit for dependents. Neither an earned income credit nor a credit for interest on obligations of the United States and its instrumentalities is allowed in computing the surtax net income.

Items Not Reportable as Income

The following items are not required to be reported because exempt from taxation: gifts, bequests, devises and inheritances; dividends on stock of federal reserve banks, land banks, intermediate credit banks and national farm loan associations; dividends from corporate earnings accumulated prior to March 1, 1913; amounts received through health, accident or workmen's compensation insurance, and damages received by the taxpayer for illness or injuries suffered by him; life insurance proceeds paid by reason of death of the insured (where a policy matures during life the amount of the proceeds, in excess of the net premiums paid, is taxable income); corporate stock dividends of the same kind as previously held by the taxpayer in the issuing company; payments to war veterans under the Adjusted Compensation Payment Act of 1936; earned

income received from sources without the United States by a citizen who is a bona fide nonresident more than six months of the taxable year except amounts paid by the United States or any agency thereof; pensions and compensation received by veterans from the United States, and pensions received from the United States by the family of a veteran for services rendered by the veteran to the United States in wartime.

Interest on the following obligations or deposits antedating March 1, 1941, is wholly exempt, but while excluded from taxation must nevertheless be reported on the proper schedules on the 1942 returns: Obligations of a state or political subdivision thereof, Treasury bills and certificates of indebtedness, Treasury notes, except series B–1945, redeemable December 15, 1945, deposits in Postal Savings banks, and obligations of the United States issued on or before September 1, 1917, obligations of United States possessions, obligations issued under the Federal Farm Loan Act.

Interest on obligations of the H.O.L.C., Federal Farm Mortgage Corporation, and United States Housing Authority and dividends from federal savings and loan associations are exempt from normal tax, but are subject to surtax where issued prior to March 28, 1942.

Interest from Treasury bonds, including United States Savings bonds issued prior to March 1, 1941, is exempt from normal tax, but is subject to surtax except for exemption to the extent of the interest received on the first $5,000 of principal of such bonds. Example—Taxpayer holds $10,000 in principal of Treasury bonds, equally divided between issues bearing interest at 3 per cent and 4 per cent. He may claim exemption from surtax as to the interest received on the $5,000 of 4 per cent Treasury bonds.

Capital Gains and Losses

The 1942 revenue act has substantially simplified the handling of capital gains and losses from the standpoint of the taxpayer. First of all, it has changed the classifications as follows:

(1) *Short-term* capital gains and losses are those resulting from the sale or exchange of capital assets held not more than six months.

(2) *Long-term* capital gains and losses are those resulting from the sale or exchange of capital assets held more than six months.

One hundred per cent of the gain or loss is recognized on short-term transactions, and 50 per cent on long-term transactions. After applying the proper percentages of gains and losses, both short-term and long-term are treated together.

It is important to note that a net capital loss is deductible against ordinary income only to the extent of $1,000. The portion of the net capital loss which is disallowed, because it exceeds $1,000 in a given year, may be carried over to the five succeeding years to be applied against any future capital gains and also against other ordinary income up to the $1,000 maximum in each such future year.

The alternative tax has been continued in so far as a net long-term capital gain, after reduction for any net short-term capital loss, is concerned. There is, however, no longer any alternative tax in the case of a long-term net capital loss. The rate has been increased from 30 per cent to 50 per cent, but since the rate applies to only 50 per cent of the actual gain, this represents an increase in the effective rate only from 15 to 25 per cent. The alternative tax is not applicable, however, until surtax net income exceeds $18,000.

An important point for the physician who sold improved land during 1942 is that the 1942 act has repealed the artificial and unsatisfactory provision of the past several years under which land had to be separated from buildings and differently treated for income tax purposes at the time of sale. Land, under the former rule, was treated as a capital asset, but buildings and affixed equipment were not so treated because they were depreciable.

Under the 1942 amendment the entire gain or loss from a sale of improved business real estate is now treated as an ordinary gain or loss, with 100 per cent recognition for income tax purposes, except that the entire gain is treated as a capital gain, if the property was held more than six months. In such latter cases only 50 per cent of the gain is subject to tax.

If any securities issued by any corporation, including stocks, rights, bonds, debentures and other evidences of corporate indebtedness, are ascertained to be worthless and are charged off within the taxable year, the loss resulting therefrom shall be considered as a loss from the sale or exchange of capital assets *as of the close of the taxable year.*

Individuals not involved in the sale or exchange of any capital or other assets during 1942 need have no concern over these capital gains or losses provisions.

Gains or losses from the sale or exchange of property other than capital assets, by which are meant primarily such depreciable assets as a car, building, or equipment, are recognized in full for tax purposes, irrespective of the period owned by the taxpayer.

These new provisions are as yet untested either before the federal treasury department, or in the courts, and are of a highly involved character. It is recommended that any physician who made sales or exchanges of capital assets during the past year consult with his attorney or a qualified accountant before preparing his 1942 return.

Special Rule on Accrued Accounts Receivable

Certain types of taxpayers are permitted by the federal act to report income on a *cash* as distinguished from an *accrual* or due basis. This is in recognition of the fact that much taxable income is

not received by certain business and professional men until long after the tax period in which the right to receive such income accrued. This is notably true of accounts receivable, and also of notes receivable, rent and interest receivable.

Example: A physician charges his patients a total of $15,000 on his accounts receivable records in a given year, but collects only $3,000 of it in cash during that year. He also collects in cash during that same year the further sum of $9,000 in payment of services rendered by him to patients in prior tax years. His gross *cash* income for that year is thus $12,000, while his gross income on an *accrual* basis is $15,000.

Generally speaking, it is advantageous from a tax standpoint for a physician to report and pay only what is actually received in accounts, notes, interest and similar items, because his losses from these sources are so much higher than those of a commercial concern.

Since 1934 there has been a provision in the revenue act which required that upon the death of a taxpayer a valuation should be placed on all accounts and other receivables which were uncollected at the time of such taxpayer's death, and that such valuation was to be added to the taxpayer's cash income in the year of death, although none of such accounts were in fact collected until subsequent to such death. The effect of this statute was to put on an accrual basis a person who died in the course of a tax year, and who had hitherto been on a cash reporting basis. It had the effect of subjecting to income taxation what was considered the fair valuation of all unpaid accounts due to the taxpayer at the time of his death.

Important 1942 Amendment

Without considering the legal basis for the above rule, it clearly worked an increasing hardship on physicians and other professional men, particularly as receivables have mounted during the past decade along with income tax rates. A 1942 amendment changes the above rule by providing that amounts which are accrued only by reason of the death of the taxpayer shall no longer be included in computing the taxable net income for the period in which falls the date of the taxpayer's death. In other words, it is no longer necessary to accrue for income tax purposes and place a valuation upon the accounts and other receivables due as of the date of death. One of the serious features of the former rule was that the estate of the physician or other taxpayer affected first had to pay an income tax on uncollected receivables and then had to pay an estate tax upon the same accounts (if the estate was otherwise subject to such latter tax), even though *no cash* was in fact received by the estate from the accounts within the time that the two taxes became due and were paid.

The 1942 amendment above summarized is extremely important to the practicing physician and may mean a saving of many thousands of dollars in taxes to his estate.

It should be emphasized that accounts and other receivables do not by any means escape taxation under the amendment, for such a result would be inequitable from the standpoint of the government. A valuation is still placed upon them, and if the estate is otherwise subject to a federal estate tax the accounts in that sense still pay one tax during the course of probate. The accounts themselves, however, are not treated as income excepting as they are collected. At the time of collection such income is taxed to the estate or to the beneficiary of the estate, depending upon the recipient.

Refund for Taxed Accounts

In situations in which an income tax has hitherto been paid between the end of 1933 and the end of 1942, by the estate of a deceased taxpayer such as a physician, upon accounts and other receivables accrued under the former rule, a claim for credit or refund may be filed and relief otherwise granted under the terms of the new amendment.

This matter may be one of very real importance to widows, children, and others who survive physicians, and should be brought to the attention of the attorneys who conducted the original probate proceedings, if that be practicable.

The above amendment is a very favorable one to taxpayers particularly at this time. Like all other tax provisions, it is likely to be rather strictly construed by the tax authorities, and will not warrant any relaxation of sound business practices and the keeping of adequate accounting and other records. It is important for the practicing physician to observe the following bookkeeping precautions which may have the effect of reducing his tax liability in a proper and legal manner:

1. Do not enter on your books, as receivables, accounts due from patients, notes due from patients, interest from loans or other obligations due you, or rental to which you are entitled from leased property, where such items are of doubtful collectibility or known to be uncollectible. Your estate may have trouble in proving an account is bad and getting an allowance for it, thereby compelling payment of a tax on an account which neither you nor your heirs will ever collect.
2. Write off known bad accounts and notes at least annually, even though you are reporting on a cash basis. If you are reporting on an accrual basis, set up adequate reserves for bad and uncollectible accounts and charge against the reserve all accounts known to be in this classification.
3. Keep in your files such information as your patients and other debtors volunteer, or which you obtain from other sources, which will provide a basis for showing such accounts to be uncollectible, or at least very doubtful.

This rule is limited to the federal income tax, does not affect the state income tax due, and does

not involve the valuation of your assets or the computation of taxes due from your estate either to the federal or state governments.

Personal Exemptions and Credit For Dependents

In the case of a single person who is not the head of a family or of a married person not living with husband or wife, a personal exemption of $500 is allowed as a deduction from net income subject to tax. In the case of the "head of a family," or of a married person living with husband or wife, a personal exemption of $1,200 is allowed. If a husband and wife living together make separate returns, the personal exemption may be taken by either of them or divided between them, but may not exceed $1,200 in the aggregate.

A person serving in the Army or Navy *below the grade of commissioned officer* may exclude from his compensation received from the United States for active service in such forces during the war $250 in the case of a single man and $300 in the case of a married man or head of a family. Since all physicians are commissioned officers this additional exclusion from gross income is *not* available to them, and is explained here only to assist in avoiding misunderstanding.

A credit of $350 is allowed for each person, except as noted below, other than husband or wife, dependent upon and receiving his *chief* support from the taxpayer, if such dependent person is under eighteen years of age, or is incapable of self support for mental or physical reasons.

The 1941 act has added a provision that if the taxpayer did not occupy the status of head of a family except for one or more dependents for whom he would be entitled to the above credit of $350 each, such credit shall be disallowed as to such dependent, or as to one of such dependents if there be two or more.

The full application of the "first dependent" rule, as it has been termed, has not yet been determined. It would seem clear that the rule has no application to the situation in which the taxpayer living with husband or wife and maintaining a home for such spouse also has one or more dependents. Neither has the rule application to the situation in which the taxpayer who does not claim the status of head of a family asks credit for one or more dependents. It does have application to a widower supporting two or more children under the age of eighteen. In such cases the credit is disallowed as to one of the dependents, but is allowable as to the others. This rule has the intent and the effect of further increasing the taxes payable by the person claiming the status of head of a family and also asking a dependency credit.

Compensation of Locum Tenens

In the case of the physician who has been called into military service the problem arises as to the manner in which the professional income of his practice is to be handled during his absence. In some cases he may bring in a substitute physician or locum tenens, with the intention that such person keep his office in operation and hold the practice intact. In other cases the physician called into service may request a colleague to take over his patients without endeavoring to keep his office in operation. The financial arrangements in this situation should be such as will not add to the income tax burden, nor violate the fee splitting statute. Any such arrangement should be by formal contract which is drafted by the physician's attorney, and which will take into account not merely those arrangements which are best calculated for the interest of the patients but are also within the terms of the income tax acts and the fee splitting statute.

A double tax on the professional income can be best averted by paying a prearranged salary to the substitute physician. This could vary in accordance with gross income, with the justification that the varying time and effort required in different months would be reflected by increase or decrease in cash income. Such a salary would be deductible for income tax purposes, and would also avoid any complications under the fee splitting statute. See "Agreements of Lease and Locum Tenens," page 77, and "Fee Splitting," page 81, for discussion of those subjects.

Partial Deduction Medical Expenses

Among the 1942 amendments is a new section which gives partial recognition to the cost of medical care by including it among the deductions permitted from gross incomes. The new provision states that expenses paid during the taxable year by the taxpayer may be deducted under the following circumstances:

1. Where not compensated for by insurance or otherwise.
2. Where such payments are for the medical care of the taxpayer, his spouse, or a dependent recognized by the revenue act.
3. A husband and wife who file a joint return may deduct only such medical expenses as *exceed* 5 per cent of the aggregate net income of such husband and wife, where such income was first computed without the benefit of the deduction, and the maximum deduction for the taxable year may not exceed $2,500 in the case of such husband and wife.
4. An individual who files a separate return may deduct only such medical expenses as *exceed* 5 per cent of his net income computed without the benefit of this deduction, and the maximum deduction for the taxable year may not exceed $2,500 for the head of a family or $1,250 for any other individual.

The term "medical care" is defined by the statute to "include amounts paid for the diagnosis, cure, mitigation, treatment, or prevention of disease, or for the purpose of affecting any structure or function of the body (including amounts paid for accident or health insurance)."

The above definition is broad enough to include not only medical care but dental care, hospitaliza-

tion, medication and therapy. Although regulations are not yet available on the new section, it would seem reasonable to interpret the above wording as being broad enough to include also the cost of hospitalization insurance and the cost of travel and living expenses undertaken *solely* for reasons of health.

Although this new provision would not ordinarily have direct application to a physician's personal situation, or that of his immediate family, it will undoubtedly have application in some instances. Irrespective of that fact physicians will inevitably be asked a great deal about the new section during the next year and should therefore familiarize themselves with the point. The physician who explains the matter should be careful to emphasize that only such costs of sickness care as are *in excess of* 5 per cent of the net income of the taxpayer are deductible under this provision.

Example: If a taxpayer had a net income, before deducting sickness care, of $2,000, and the total of medical, hospitalization and dental care, plus accident and health insurance, for himself and family in a given tax year was $250, that portion of the $250 which represented 5 per cent of such income, or $100, would *not* be deductible. Only the balance, or $150, would be deductible under the law on these particular facts.

Optional Tax on Gross Incomes of $3,000 or Less

The 1941 act added a new "Supplement T" to the Internal Revenue Code, the purpose of this provision being to simplify the preparation of returns and the determination of tax for individuals whose gross income is $3,000 or less. Such income under a 1942 amendment must be derived solely from salary, wages, compensation for personal services, dividends, interest, or annuities. Taxpayers with income from other sources are *not* permitted to use the optional tax method, even though their gross income is $3,000 or less. This includes persons who derive any income from rents and royalties, which, under the 1941 law, could be included in this return. It also includes those who derive any income from the sale or exchange of capital or ordinary assets. The taxpayer whose gross income is $3,000 or less and is derived from one or more of the above sources has the *option* but not the duty to make a return on Form 1040A, under Supplement T. Election to make his return under Supplement T is irrevocable once the income tax form prescribed thereunder has been filed. Thus, a taxpayer who filed a return under this provision and later discovered that he had overlooked a substantial bad debt, loss, or other deduction, would not be permitted to file an amended return claiming such deduction.

The returns made under this supplement are much simpler than those made on large Form 1040 for the very reason that they do not take into account items of business expense, depreciation, repairs, losses, taxes and interest, and other substantial deductions. Generally speaking, where there are substantial deductions the tax will be lower if computed in the regular way on Form 1040.

Although no business expenses, losses, or taxes are deductible under this supplement, the taxpayer is permitted to deduct the same personal exemptions and credit for dependents as would be allowed him were he making a return on Form 1040.

There has been an important change in the determination of the status of the taxpayer. Under the 1941 provision the marital status of the taxpayer on the last day of the year determined his status for the whole year. By status for income tax purposes is meant whether he is married, whether he has one or more children or other dependents, and whether he is the head of the family. Under the 1942 amendment, status for purposes of personal exemption and credit for dependents is determined as of July 1 instead of at the end of the year for those using optional form 1040A. This is more liberal in some instances than the rule governing those who make the usual returns on Form 1040, which rule requires the apportionment of status on the basis of the nearest month in which a change occurs.

The credit for dependents is $385 by contrast with $350 which is allowed those making a return on Form 1040.

A husband and wife living together may file either joint or separate returns under Supplement T, but if separate returns are filed one may not file Form 1040A and the other Form 1040. *Both must use the same kind of return.*

Generally speaking, Supplement T is advantageous only where the deductions which the taxpayer might otherwise claim do not exceed 7 per cent of his *gross* income. If such expenses, depreciation and other items do exceed 7 per cent of the taxpayer's gross income it would be to his tax advantage to make the return on the large Form 1040.

Information at Source

Every person making payments of salaries, wages, interest, rents, commissions, or other fixed or determinable income of $500 or more during the calendar year 1942 to another person, is required to make a return on Form 1099 showing the amount of such payments and the name and address of each recipient, except that a return need not be made for payments of salaries or other compensation for personal services aggregating less than $1,200 made to a married individual. This form will be furnished by any Collector of Internal Revenue upon request and must be forwarded to the Commissioner of Internal Revenue, Sorting Section, Washington, D. C., in time to be received not later than February 15, 1943.

No informational return will be required from a taxpayer for a tax year ending after December 31, 1942, covering wages and salaries from which a Victory Tax has been withheld.

Deductions

Deductions which will be allowed on the tax return, some of which are peculiar to physicians, are listed below. The number given after each heading refers to the paragraph numbering on the pages following. The paragraphs explain in detail how to arrive at the deductions and depreciation.

With reference to depreciation allowable, the rate of depreciation not only depends on the prospective life of the property when acquired but also on the particular conditions under which the property is used as reflected in the taxpayer's operating policy.

The rates given below are therefore suggestive and tentative rather than final in character.

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  Salary of chauffeur.
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B. Explanation of Deductions

1. Automobiles. The cost of operation and maintenance of an automobile used in making professional visits is deductible. These costs include gasoline, oil, tires, insurance, repairs, garage rental, chauffeur's wages and depreciation. If the same car is used for both professional and personal purposes, only such part of the maintenance and depreciation as arises out of the use for professional purposes is deductible. Sums spent for taxi, bus, or railroad fare, while on professional calls, are deductible.

Depreciation is based upon the estimated useful life of the car. If that period be four years, 25 per cent depreciation based on cost price may be taken annually for four years. What has been said with respect to automobiles applies to other motive equipment.

2. Bad Debts. If the physician's books are kept according to the "Cash Receipts and Disbursements" system, he may not charge off any unpaid debts because "if his books are kept according to this system, he is only reporting as gross income those accounts which have proved to be good, and therefore bad accounts cannot be deducted because they have already been excluded."

If the books are kept upon an "accrual basis" (that is, on the basis of expenses actually incurred and payable even though not yet paid, or income earned although not yet collected), it is permissible

to charge off all debts which have been definitely ascertained to be worthless, and have been charged off on the books or records during the fiscal year covered by the report. *We urge all members who may be keeping accounts on the "accrual basis" to secure permission to change to a cash basis.* (In this connection see "Special Rule on Accrued Accounts Receivable," page 61.)

3. **Library.** Most physicians maintain a professional library. Taken as a whole it is doubtful whether the useful life of such a library exceeds ten years. Accordingly annual depreciation equal to 10 per cent of the cost of such library may be deducted.

4. **Medical Supplies and Instruments.** Medicines used in the physician's office to treat patients, bandages, laboratory materials, and all other medical supplies required for the operation of a physician's office may be deducted as necessary expenses, as may equipment, the life of which is less than one year. The average useful life of surgical instruments and equipment generally is now estimated at ten years which means that 10 per cent of the cost may be taken as annual depreciation. Roentgen ray equipment may be depreciated at 10 per cent of cost annually.

5. **Office Expense.** General office expense is deductible. Among the principal items are heat, light, office supplies, telephone, rentals, water, office equipment having a useful life of a year or less, and depreciation on office furnishings and fixtures. Ten per cent of original cost is a reasonable average depreciation rate for office equipment, furnishings and fixtures.

6. **Office Rent.** If a physician pays rent to another person for office space, he is permitted to deduct the amount from his gross income. This includes regular office space in a rented home provided office hours are maintained there. Where a physician maintains his offices in a rented home he may deduct as rental expenses only that proportion of the total rent paid which his office space bears to the entire house. If he owns his home and maintains an office in it, he cannot claim a deduction for office rent.

7. **Professional Dues and Subscriptions.** Dues paid to professional associations to which a physician belongs in the interest of his profession are deductible. Subscriptions to medical journals or scientific publications are likewise deductible.

8. **Taxes and Licenses.** Any taxes paid upon materials required in professional work are exempt. All licenses which the physician is required to take out may be deducted. This includes the license to prescribe alcohol, narcotic license, automobile license, local occupational and reregistration taxes, state taxes on gasoline and motor oil for professional use of car, state income taxes paid, payments made under the Wisconsin unemployment compensation act and payments made by the physician as an employer under Titles VIII and IX of the Social Security Act. The social security tax deducted from the income of a salaried physician is not deductible by him, however, since it is considered an income tax.

9. **Traveling Expenses.** Traveling expenses necessary for professional visits to patients are deductible. Traveling expenses in bona fide attendance upon scientific meetings are deductible. The expenses of attending postgraduate medical courses are *not* deductible, however.

10. **Wages and Salaries.** Deductions are permitted for the salary of a nurse, laboratory assistant, stenographer or clerical worker employed in the office so long as the duties of such persons are in connection with the physician's professional work. Wages paid to maids taking care of the office and answering the telephones are also deductible, as are any sums paid employees for services rendered in connection with the taxpayer's practice, or the care and treatment of patients.

11. **Miscellaneous. (a) Legal Expenses.**—Legal expenses incurred in connection with the taxpayer's profession or business, including the prosecution of tax assessment or refund cases, are deductible, but legal fees paid for general personal legal services are not deductible. Expenses incurred in the defense of a suit for alleged malpractice are likewise deductible as business expense. Expenses incurred in the defense of a criminal action, however, are not deductible.

(b) **Insurance Premiums**—Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. Under professional equipment is to be included any automobile belonging to the physician and used for strictly professional purposes.

(c) **Laboratory Expenses**—The deductibility of the expenses of establishing and maintaining laboratories is determined by the same principles that determine the deductibility of other corresponding professional expenses. Laboratory rental and the expenses of laboratory equipment and supplies and of laboratory assistants are deductible when, under corresponding circumstances, they would be deductible if they were part of a physician's general office expense.

(d) **Losses by Fire, Theft, etc.**—Loss of and damage to a physician's equipment by fire, theft or other cause, *not compensated by insurance or otherwise recoverable*, may be computed as a business expense and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent it has not been made good by repair and the cost of repair claimed as a deduction. Deductions may likewise be taken for loss of or damage to *nonprofessional* property of a physician caused by fire, flood, theft or otherwise, *where not compensated for by insurance or otherwise.*

(e) **Sale of Spectacles**—Oculists who furnish spectacles, etc., may enter as income money received

from such sales and deduct as an expense the cost of the article sold. Entries on the physician's account books should, in such cases, show charges for services separate and apart from charges for spectacles.

1943 Victory Tax

Beginning January 1, 1943, a 5 per cent tax, known as the "Victory Tax," will be imposed on every person, with certain exceptions, having a gross income of more than $624 a year. This is *in addition to* the regular income tax, and is based upon "Victory Tax Net Income" by which is generally meant gross income, (excluding capital gains and losses, and taxable interest from U. S. obligations issued prior to March 1, 1941) less business expenses, interest on business indebtedness, and certain other allowable deductions.

No regulations have yet been issued by the United States Treasury Department on this new tax, nor are all tax forms yet available. It is thus impossible at this time to offer a detailed analysis of all the provisions and implications of the new law. The outline below is intended to assist the physician in his dual capacity as (1) an agent for the government in withholding and remitting the tax due from his employees, and (2) as a taxpayer in making a return and himself paying the Victory Tax due on his own 1943 income in March of 1944.

1. *Income subject to law, and exemptions.* Interest, rent, dividends, and other investment income, and the compensation of all employees is subject to the tax. This includes the compensation of public officers, elected officials, and those working for any branch of government, except where the wages are derived from the following sources:

(1) Services performed in the armed forces of the U. S., other than pensions and retired pay.
(2) Agricultural labor.
(3) Domestic service in a private home or college fraternity.
(4) Casual labor not in the course of the employer's trade or business.
(5) Service for a nonresident alien, foreign partnership, or foreign corporation not engaged in trade or business in the United States.
(6) Service for a foreign corporation, or any corporation or other instrumentality thereof.
(7) Services performed as an employee while outside the United States, except where the major part of the services performed during the calendar year by such employee for his employer are performed within the United States.

2. *Withholding and computation of tax on wages and salaries.* Every employer who has an employee whose wages do not come within one of the above exemptions is required to *withhold* from the wages of such employee and to pay over quarterly to the federal government the amount of the tax based upon that portion of each employee's wages which is subject to the tax. The amount subject to tax is 5 per cent of the compensation in excess of $12 per week, where the payroll period is on a weekly basis; where the payroll period is biweekly the amount of tax to be withheld is 5 per cent of the compensation in excess of $24; where the payroll period is semimonthly the amount of tax to be withheld is 5 per cent of the compensation in excess of $26; where the payroll period is monthly, the amount of the tax is 5 per cent of the compensation in excess of $52. This is another way of saying that each person is allowed a specific exemption of $624 a year free from the withholding provisions of the Victory Tax, and as a general proposition, he is taxable on 5 per cent of his gross income both from professional services and investments in excess of that figure.

3. *Computation of special amounts and periods.* When the physician receives his reporting forms and instructions, he will find tables which tell him how much tax to pay for varying amounts of compensation in excess of $12 a week, and also what to withhold in the case of compensation for periods of less than one week and compensation of less than $12.

4. *Employers subject to law.* The term "employer" includes not only persons and corporations engaged in trade or business, but also a professional employer such as a physician, or a group of physicians, and such religious organizations as churches and charitable organizations such as hospitals. It also includes educational institutions, clubs, social organizations, and societies.

5. *Quarterly returns.* Every employer who pays wages after December 31, 1942, which are subject to the Victory Tax, is required, first to withhold the proper amount of tax from each payment to his employee and must then hold the money at his own risk and pay it over to the federal government quarterly, along with that due as a Victory Tax from any other employee or employees.

The first reporting period will begin January 1 and end March 31, 1943, and the return must be made and the tax paid for that quarter by April 30, 1943. The procedure will not be wholly new to the physician and other employers, since this is substantially the procedure already followed on the quarterly Social Security Tax. The chief difference will be that the first $12 per week, or corresponding amount in the case of a different payroll period, is *not* subject to the Victory Tax and that the amount to be withheld is 5 per cent under the Victory Tax instead of 1 per cent as under the Social Security Tax.

The quarterly returns of each employer physician are to be made on treasury form V–1 which is entitled "Return of Victory Tax Withheld." These are expected to be available shortly, and will in most cases be mailed to the physician by the Col-

lector of Internal Revenue at Milwaukee. *The physician who has not received such a form by March 1, 1943, should write for one, since his liability to make a return is not dependent on whether he received a form from the Collector.*

An annual reconciliation statement will also be required which will summarize the quarterly statements made during the year. This will not be due until January 31, 1944, however, and detailed instructions on its preparation will undoubtedly be made available by the government long before that time.

It is very important that physicians and all other employers observe the rule that all wages and salaries paid after December 31, 1942, are subject to the withholding tax even though part or all the services were performed during 1942. This is true, of course, only of employment subject to tax and does not include the exempt employments earlier noted.

6. *Tax statement to employees.* By January 31, 1944, and by the end of each January thereafter, or within thirty days after the termination of employment in any particular case, if that occur within the calendar year, each employer is required to prepare in duplicate a form entitled "Statement of Victory Tax Withheld." This is known as treasury form V–2, is now in preparation, and will be supplied to employers upon request to the Collector of Internal Revenue at Milwaukee. This form must show the period covered by the statement, the wages of the employee during such period, and the amount of the tax withheld and collected on such wages. One copy of such statement is to be given the employee and the other to be transmitted to the Collector of Internal Revenue with the quarterly form (V–1) which is next due.

7. *Current and postwar tax credits.* Current credits are allowed for life insurance premiums paid on insurance in force September 1, 1942; also for payments on personal indebtedness and on war bond purchases. The total current credits allowable for any given tax year may not exceed the amount of the postwar credit or refund. The latter amounts to 25 per cent of the tax in the case of a single person, with a maximum of $500; and 40 per cent of the tax for a married person or head of a family, with a maximum of $1,000; plus 2 per cent for each dependent with a maximum of $100 each. The postwar credit or refund is reduced by the amount of current credit allowed in any given taxable year. Amounts withheld from an employee's wages in excess of the net Victory Tax due, after computing the proper postwar credit, may be applied as a credit against his *regular* income tax, or may be the basis of a *current* refund. A person whose *current* credits are less than his *postwar* credit may make a refund claim for the difference within seven years after the cessation of hostilities. No interest is allowed on such a postwar credit or refund. *Credits do not in any event reduce the amount of the original withholding tax and must not be confused with the specific wage exemptions already enumerated.*

8. *Employee must make annual return.* An employee whose wages are subject to the 5 per cent withholding tax in excess of his compensation over $12 a week must also make an *annual* return. The first one will be due on or before March 15, 1944, and must show all of his nonexempt wages or other income from personal services, as well as all investment income received during the calendar year 1943. The chief reasons for requiring this individual employee return are, first, that the taxpayer may have investment or other income which is subject to the Victory Tax, and, second, that the return enables him to establish a proper basis for claiming a current or postwar credit or refund.

9. *Individual physician subject to tax.* If a physician is not a member of a partnership or clinic but is employed by either, his salary is clearly subject to the *withholding* feature of the Victory Tax. In the case of a physician practicing either alone, or as a member of a partnership or clinic, the net professional and investment income of such physician is likewise subject to the Victory Tax on an *annual* basis. The annual return will be due on or before March 15, 1944, will cover the year 1943, must include professional and investment income, and will be made at the same time as the 1943 income tax return. Accordingly, the self-employed physician must make provision for this *additional* tax obligation, preferably on a monthly basis throughout the year 1943. As a rule of thumb, he should set aside each month 5 per cent of his *net* professional and investment income for that month in excess of $52.

10. *Victory tax is additional.* It should again be emphasized that the Victory Tax is independent of *and in addition to* the individual *income tax* and also the *Social Security Tax* with which the physician is already familiar. The fact that a physician is self employed means only that his Victory Tax is on an *annual* instead of a *payroll* basis.

11. *Penalties.* The law imposes severe penalties upon the employer or other person who makes out a false or fraudulent receipt on form V–2 to his employee, or who wilfully fails to furnish one, or who wilfully fails in any other respect to comply with the provisions of the Victory Tax law. Each physician employer should be careful to withhold the amount of the tax from his subject employees on and after January 1, 1943, and to obtain and return on time all forms required by law in connection with this new tax.

II. STATE

General Instructions

Returns of 1942 income must be made to the assessor of incomes of the district in which the taxpayer resides, on or before March 15, 1943. A written extension of the time in which to file may be granted for sickness or other sufficient cause by the

assessor of the department of taxation for the district in which the taxpayer lives. Such extension must be on written request, may not exceed thirty days, is discretionary in the assessor, and will not be granted because of mere neglect of the taxpayer.

Every resident including minors from eighteen to twenty-one years of age, who received a net income of $800 or more if single, and $1,600 or more if married, must file a return whether notified to do so or not. The income of an emancipated minor under eighteen years should be included in the return of his father.

Liability to Make Tax Return

If the status of the taxpayer changes during the taxable year, insofar as it affects personal exemption for husband and wife, head of family, or dependents, such personal exemption shall be apportioned in accordance with the number of months before and after such change, disregarding a fractional part of a month unless it amounts to more than a half month, in which case it shall be considered as a month.

Every person having a legal residence in Wisconsin and every other person maintaining a permanent place of abode here, or spending in the aggregate more than seven months of the income year within the state, shall be deemed to be residing in Wisconsin for purposes of determining liability for income taxes and surtaxes. Liability for income taxation which follows the residence of persons moving into or out of the state in the tax year shall be determined by the ratio of time which the residence of such taxpayer in the state bears to the entire tax year. Deductions and personal exemptions are prorated on the basis of time of residence within and without the state, and the net income of such person assignable to the Wisconsin residence shall be used in determining the income subject to tax.

Income Tax Returns

The normal tax, which is graduated, varies from 1 per cent on the first $1,000 of net income to 7 per cent on net incomes in excess of $12,000. The teachers' retirement fund surtax is based on one sixth of normal taxes after deducting $37.50 from the net normal tax. The legislature continued the 60 per cent emergency surtax for the calendar or fiscal years 1941 and 1942. These are to be computed as before by the taxpayer on the same return with the normal tax, and are subject to the same personal exemptions as the normal tax. Full instructions will appear on the 1942 tax return.

Income From United States Taxable

All wages, salaries or fees derived from personal services performed for the United States or any agency or instrumentality thereof are now taxable, effective January 1, 1939. This changes the former rule exempting income from such sources.

Capital Gains and Losses

The former provisions of the statutes relating to computation of capital gains and losses for surtax purposes have been repealed. Thus, full gains or full losses are now recognized irrespective of the time the asset was held, instead of being graduated, as formerly, on the basis of the time the asset was held.

Limits on Federal Tax Deduction

Hitherto all federal income taxes have been deductible on the state return, subject to certain adjustments and exceptions. The 1941 Legislature has imposed the further limitation, which will affect many taxpayers, that the deduction for *all* United States income excess or war profits and defense taxes shall be limited to a total amount not in excess of 3 per cent of the taxpayer's net income computable without the benefit of the deduction for such federal taxes, and *before* the deduction of contributions.

Example: The taxpayer's net income, for purposes of the Wisconsin return, before deduction of any United States taxes paid during 1942 and before deduction of contributions, is $5,000. He paid federal income taxes of $400 during 1942. Under the above limitation he could deduct only 3 per cent of $5,000 or $150 for federal taxes, although he had actually paid $400. This has the effect of subjecting a larger part of the taxpayers net income to the Wisconsin law, even though the rates as such have not been increased.

Important 1942 Income Tax Rules

The Wisconsin Legislature did not meet during 1942, and there were thus no changes in the tax statutes the past year. There were no Supreme Court decisions during the year which affected the ordinary income tax problems of the physician. The Board of Tax Appeals, however, made two decisions during 1942 which may hold some importance for a number of physicians.

The first of these provides that dividends received on paid-up life insurance policies are no longer taxable income and need not even be reported on the return. Physicians who have paid-up life policies should note this new rule and obtain a refund if they have, in the years still open to refunds, reported dividends from such policies in their gross incomes and paid a tax which included this item.

The second decision ruled that social and luncheon club dues are *not* deductible as "ordinary and necessary expenses" actually paid in carrying on the profession, in the case of physicians, from which the income is derived. The physician, in common with other taxpayers, can therefore *not* deduct such items as income tax expenses.

Instructions on the Filing of Separate Income Tax Returns For Husband and Wife

Section 71.09 (4) (c) requiring that the incomes of husbands and wives be combined for assessment purposes has been held unconstitutional by the

United States Supreme Court. To give effect to this decision the Tax Commission has adopted the following regulations:

1. Wives must file a separate return on Form 1W if they have income of their own, but in case they have no income no return need be filed.

2. In the event that both husband and wife have income and file separate returns, the personal exemption of $17.50 for the head of a family may be divided between the two according to their own choice, that is to say, the husband may claim it all, or the wife may claim it all, or they may divide it between them as they see fit.

3. The income of children under eighteen years of age shall be included in the return of the husband, widow or head of a family, and the personal exemption for such children or dependents shall be allowed to the husband or may be divided between him and his wife as they may elect, or shall be allowed to the widow having such children. The exemption allowed to the head of a family, other than a widow or widower, supporting children under the age of eighteen shall be limited to a deduction of $17.50 from the tax.

Personal Credits and Exemptions

The statutes themselves are so clear as to personal exemptions, credits for dependents, and the date determining the personal status of a taxpayer for income tax purposes that they are quoted here in full.

"71.05 Exemptions. (1) There shall be exempt from taxation under this chapter income as follows, to wit:

(a) Pensions received from the United States.

(b) All inheritances, devises, bequests and gifts received during the year.

(c) All insurance received by any person or persons in payment of a death claim by any insurance company, fraternal benefit society or other insurer, except insurance paid to a corporation or partnership upon the policies on the lives of its officers, partners or employees.

* * * *

(2) There shall be deducted from the tax after the same shall have been computed according to the rates in section 71.06, a personal exemption for natural persons as follows:

(a) For an individual, eight dollars.

(b) For husband and wife or head of a family, seventeen dollars and fifty cents. For the purposes of this chapter, the term 'head of a family' means a natural person who maintained a household and supported therein himself and one or more persons who were dependent upon him for support; but no additional exemption shall be allowed for those dependent upon the head of a family except in case of a widow or widower supporting children under the age of eighteen years.

(c) For each child under the age of eighteen years who is actually supported by and dependent upon the taxpayer for his support, an additional four dollars.

(d) For each additional person, except persons defined in subsection (2) (c) of section 71.05, who is actually supported by and entirely dependent upon the taxpayer for his support an additional four dollars, except in case of head of a family. In computing taxes and the amount of taxes payable by persons residing together as members of a family, the income of * * * each child under eighteen years of age shall be added to that of the husband or father, or if he be not living, to that of the head of the family and assessed to him except as hereinafter provided. The taxes levied shall be payable by such husband or head of the family, but if not paid by him may be enforced against any person whose income is included within the tax computation.

(e) If the status of the taxpayer, insofar as it affects the personal exemption for husband and wife, head of family and/or dependents, changes during the taxable year, the personal exemption shall be apportioned, under rules and regulations prescribed by the tax commission, in accordance with the number of months before and after such change. For the purpose of such apportionment a fractional part of a month shall be disregarded unless it amounts to more than a half month, in which case it shall be considered as a month."

Deductions

A. Statute

The statute is so explicit on what constitutes allowable deductions of major items of expense that it has seemed advisable to insert portions of it for the aid of physicians making state returns.

"71.04 Deductions from incomes of persons other than corporations. Persons other than corporations, in reporting incomes for purposes of taxation, shall be allowed the following deductions:

(1) Payments made within the year for wages or other compensation for services actually rendered in carrying on the profession, occupation or business from which the income is derived. But no deduction shall be made for any amount paid for services actually rendered in the carrying on of the profession, occupation or business from which the income is derived unless there be reported the name and address and amount paid each person to whom a sum of seven hundred dollars or more shall have been paid for services during the assessment year. No deduction shall be allowed under this section for any amounts expended for personal, living or family expenses.

(2) The ordinary and necessary expenses actually paid within the year in carrying on the profession, occupation or business from which the income

is derived, including a reasonable allowance for depreciation by use, wear and tear of the property from which the income is derived * * *

(3) Losses actually sustained within the year and not compensated by insurance or otherwise, provided that no loss resulting from the operation of business conducted without the state, or the ownership of property located without the state, may be allowed as a deduction, and provided further that no loss may be allowed on the sale of property purchased and held for pleasure or recreation and which was not acquired or used for profit, but this proviso shall not be construed to exclude losses due to theft or to the destruction of the property by fire, flood or other casualty. No deduction shall be allowed under this subsection for any loss claimed to have been sustained in any sale or other disposition of shares of stock or securities where it appears that within thirty days before or after the date of such sale or other disposition the taxpayer has acquired (otherwise than by bequest or inheritance) or has entered into a contract or option to acquire substantially identical property and the property so acquired is held by the taxpayer for any period after such sale or other disposition.

(4) Dividends, except those provided in section 71.02 (2) (b) 2 and 3, received from any corporation conforming to all of the requirements of this subsection. Such corporation must have filed income tax returns as required by law, and the income of such corporation must be subject to the income tax law of this state. The principal business of the corporation must be attributable to Wisconsin, and for the purpose of this subsection any corporation shall be considered as having its principal business attributable to Wisconsin if 50 per cent or more of the entire net income or loss of such corporation after adjustment for tax purposes (for the year preceding the payment of such dividends) was used in computing the average taxable income provided by chapter 71 * * *

(5) Interest paid within the year on existing indebtedness; provided, the debtor reports the amount so paid, the form of the indebtedness, together with the name and address of the creditor. But no interest shall be allowed as a deduction if paid on an indebtedness created for the purchase, maintenance or improvement of property, or for the conduct of a business, unless the income from such property or business would be taxable under this chapter.

(6) Taxes other than inheritance and special improvement taxes upon the property or business from which the income hereby taxed is derived paid by such persons during the year, including therein taxes imposed by the state of Wisconsin or the United States government as income taxes; provided, that such portion of the deduction for federal income taxes as may be allowable shall be confined to cash payments made within the year covered by the income tax return; and provided further, that deductions for income taxes paid to the United States government shall be limited to taxes paid on net income which is taxable under this chapter; and provided further that income taxes imposed by the State of Wisconsin shall accrue for the purposes of this subsection only in the year in which such taxes are assessed.

(6a) The deduction for all United States income, excess or war profits and defense taxes shall be limited to a total amount not in excess of 3 per cent of the taxpayer's net income of the calendar or fiscal year as computed without the benefit of the deduction for said United States income, excess or war profits and defense taxes, and before the deductions of amounts permitted by subsection (7) of this section. In no event shall any taxpayer be permitted hereunder a total deduction in excess of the actual amount of United States income, excess or war profits and defense taxes paid, and otherwise deductible.

(7) Contributions or gifts made within the year to the state or any political subdivision thereof for exclusively public purposes, or to any corporation, community chest fund, foundation, or association operating within this state, organized and operated exclusively for religious, charitable, scientific, or educational purposes, or for the prevention of cruelty to children or animals, no part of the net income of which inures to the benefit of any private stockholder or individual, to an amount not in excess of ten per centum of the taxpayer's net income of the calendar or fiscal year as computed without the benefit of this subsection.

* * *

(10) Amounts contributed for the given period to the unemployment reserve fund established in section 108.16 of the statutes, but not the amounts paid out of said fund.

* * *

(12) Any and all sums not to exceed eight hundred dollars paid by any person whose total income shall be three thousand dollars or less by way of alimony to a former spouse and not to exceed four hundred dollars each for the support of minor children under any order or decree of any court."

B. Index to Deductions

This index is designed to assist the physician in ascertaining what deductions are allowable. The number given after each heading refers to the paragraph numbering on the pages following. The paragraphs explain in detail what deductions and depreciation are allowable.

Automobiles, 1.
  Depreciation.
  Insurance, 1, 4.
  Maintenance.
  Professional use.
  Repairs.
  Salary of chauffeur.
Bad debts, 2.
Bandages, 9.
Conventions, 8.

Depreciation.
  Automobiles—25 per cent annually of cost price, 1.
  Instruments, 9.
    10 per cent annually of cost price of surgical instruments and general equipment; 10 per cent on roentgen ray equipment.
  Medical library, 6.
    10 per cent annually of cost price.
  Office equipment, 10.
    10 per cent annually of cost price.
Dividends received, 3.
Dues, 12.
Equipment.
  Office, 10.
  Professional, 9, 16(a).
Fire, loss by, 7.
Instruments, 9.
Insurance premiums, 4.
  Automobile, 1.
  Malpractice, 4.
  Professional equipment, 4.
Interest paid, 5.
Laboratory materials, 9, 16(a).
Legal expenses, 16(b), 16(d).
Library, 6.
Licenses, 13.
Losses, by fire, flood, theft, suit, etc., 7, 16(d).
Medical convention, 8.
Medical supplies, 9.
Miscellaneous, 16.
Office expenses, 10.
  Heat, light, supplies, telephone, water, short-lived office equipment, annual depreciation on furnishings and fixtures.
Office rental, 11.
Postgraduate studies, 14.
Professional conventions, 8.
Professional dues, 12.
  County Society.
  State Society.
  Special societies as:
    College of Surgeons.
    College of Physicians.
  Any other paid in interest of profession.
Professional subscriptions, 6.
Salaries, 15.
Sale of spectacles, 16(c).
Scientific meetings, 14.
Subscriptions, 6.
Taxes and licenses, 13.
  Automobile licenses.
  Federal income—3 per cent maximum.
  Import duties, etc.
  Personal property taxes.
  Professional license fees.
  Real property taxes on office owned and used by taxpayer in practice.
  Social security taxes.
  Wisconsin income taxes and surtaxes paid.
  Wisconsin unemployment taxes.
Theft, loss by, 7.
Traveling expenses, 14.
  Both professional calls and scientific meetings.
Wages and salaries, 15.
  Chauffeur, 1.
  Clerk, 15.
  Laboratory assistant, 15, 16(a).
  Maid, 15.
  Nurse, 15.
  Stenographer, 15.
  Any other employee rendering service in connection with taxpayer's practice or in the care and treatment of patients, 15.

C. Explanation of Deductions

In several instances below, references are made to numbered paragraphs of the federal portions of this tax digest. (See p. 64, Explanation of Deductions.) Such references make it unnecessary to recopy explanatory paragraphs applicable equally to the making of state and federal returns.

1. **Automobiles** (See federal digest, 1).

2. **Bad Debts** (See federal digest, 2).

3. **Dividends Received.** Cash or property dividends received from a corporation's surplus accumulated since January 1, 1911, are deductible by the persons receiving the dividends, if the following requirements are fulfilled:

(a) The corporation paying the dividend must have filed a Wisconsin income tax return for the year preceding the payment of the dividend.

(b) The income of the corporation paying the dividend must have been subject to the Wisconsin income tax law for the year preceding the payment of the dividend.

(c) The principal business of the corporation paying the dividend must have been attributable to Wisconsin for the year preceding the payment of the dividend.

If 50 per cent or more of the entire net income or loss of a corporation, after adjustment for income tax purposes, for the year preceding the payment of a dividend, was used in computing the taxable income of such corporation, it will be considered that the principal business of such corporation was attributable to Wisconsin.

Note: Stock dividends do not constitute taxable income. Liquidating dividends do not constitute taxable income until the taxpayer has recovered his cost of the stock so held. Any amounts received in liquidation in excess of the taxpayer's cost constitute taxable income.

4. **Insurance Premiums.** Premiums paid for insurance against professional losses are deductible. This includes insurance against damages for alleged malpractice, against liability for injuries by a physician's automobile while in use for professional purposes, and against loss from theft of professional equipment, and damage to or loss of professional equipment by fire or otherwise. This further includes premiums for various forms of in-

surance on the building owned and used in connection with the practice, or a fair proportion thereof where the building is also a home. Under professional equipment is to be included an automobile belonging to the physician and used for strictly professional purposes.

5. **Interest Paid.** Interest paid within the tax year on existing indebtedness may be deducted, provided that the debtor reports the amount so paid, the form of indebtedness, and the name and address of the creditor. No interest is allowed as a deduction if paid on indebtedness created for the purchase, maintenance or improvement of property, or for the conduct of a business, unless the income from such property or business would be taxable under the Wisconsin law.

Interest paid on state and federal income taxes is deductible, but interest paid on fines levied for violations of law is not allowable as a deduction.

Interest paid by an individual on indebtedness created for the purpose of acquiring a home is deductible from gross income. Likewise, interest paid by an individual on money borrowed to pay personal debts, such as hospital bills and other family obligations, is considered a proper deduction from gross income.

Interest paid by an individual on money borrowed for the purpose of securing an education is allowable even though other expenses of obtaining such education are not allowable.

6. **Library.** A fair rate of depreciation on the physician's library may be deducted covering wear and tear sustained through use. In determining the rate, however, obsolescence may not be considered since the Wisconsin income tax law does not recognize losses in value due to such causes. The fact that medical books become out of date during the course of ten years cannot be considered in determining the rate of library depreciation. An annual depreciation of 10 per cent of the cost of such library seems reasonable, however.

Costs of subscriptions to scientific medical journals essential to keep the physician abreast with the progress of his profession are deductible.

7. **Losses by fire, etc.** Loss of and damage to a physician's equipment and other property, used by him in connection with carrying on his professional practice, by fire, theft or other cause, not compensated by insurance or otherwise recoverable, may be computed as a business expense, and is deductible, provided evidence of such loss or damage can be produced. Such loss or damage is deductible, however, only to the extent that it has not been made good by repair and cost of repair claimed as a deduction. Losses on business conducted or property located outside the state are not deductible.

Losses on automobiles, aircraft, summer homes, motor boats, furniture, etc., purchased and held for pleasure are deductible from gross income where sustained because of theft, fire, flood, or other casualty. Losses on property used for both pleasure and practice are deductible only to the extent that such property was used in the practice, unless such losses were sustained through fire, flood, other casualty, or theft, in which cases the entire loss is deducted.

8. **Medical Conventions.** Ordinary and necessary expenses incurred in attending medical conventions of professional scientific societies, necessary to enable the physician to carry on his profession, are deductible.

Costs of attending professional conventions must be strictly limited to the necessary cost and expense directly attendant upon such conventions. The type of professional convention here contemplated is confined to such as are, as a general rule, ordinarily and generally attended by persons of the same professional standing as the taxpayer, as necessary to the maintenance and carrying on of their regular practice and profession.

9. **Medical Supplies and Instruments** (See federal digest, 4).

10. **Office Expenses** (See federal digest, 5).

11. **Office Rental.** If a physician pays rent to another person for office space he is permitted to deduct the amount from his gross income. This includes office space in a rented home, provided office hours are maintained. Where a physician maintains his offices in the home which he occupies as a residence, he may, if the home is rented, deduct as rent that proportion of the total rent paid which the value of his office space bears to the rental of the entire premises; and if he owns the residence, he may deduct the proper share of expenses attributable to the space so occupied, including taxes, depreciation, insurance, water, light, heat, repairs and general upkeep.

12. **Professional Dues.** Professional dues paid to professional associations to which the physician may belong in the interest of his profession may be deducted.

13. **Taxes and Licenses.** All taxes and licenses incident to the professional scope of the physician may be deducted. The following taxes would be deductible by any physician:

(a) Real property taxes paid on office owned by him and used by him in his practice.
(b) Personal property taxes paid on his apparatus and equipment.
(c) Wisconsin income taxes and surtaxes paid.
(d) Federal income taxes, provided that such deductions are limited to taxes paid in cash within the year covered by the income tax return on net income taxable under the Wisconsin law, the maximum deduction not to exceed 3 per cent of net income computed under the state law *before* contributions.
(e) All license fees incident to his profession.
(f) Automobile licenses on automobiles used exclusively in the practice of his profession. See paragraph 1 supra.

(g) Import or tariff duties and business, license, privilege, excise, and stamp taxes, are deductible if incurred in connection with the carrying on of the taxpayer's practice and profession.

(h) All social security taxes paid by the physician under Titles VIII or IX in his capacity of employer and the amount paid by him under the Wisconsin unemployment compensation act. A salaried physician, under a new rule, is required to add the amount of the social security tax paid by him to his net salary received for purposes of determining gross income. He is then permitted by the same rule to deduct the amount of the social security tax withheld from him and to include it as part of his federal income tax, subject, under the 1941 amendment, to the 3 per cent maximum rule noted in subhead (d) above.

14. Traveling Expenses (See federal digest, 9).

15. Wages and Salaries (See federal digest, 10, and state digest 16(e) below).

16. Miscellaneous.

(a) Laboratory Expenses (See federal digest, 11(c)).

(b) Legal expenses incurred in the defense of a suit for malpractice are deductible as business expense. Expenses incurred in the defense of a criminal action, however, are not deductible.

Legal expenses incurred in connection with the operation of a taxpayer's profession are proper deductions unless such business is conducted in violation of the law.

(c) Sale of Spectacles (See federal digest. 11(e)).

(d) Unclassified. Payments required to be made to others for damages growing out of the carrying on of the profession such as injury to property, interference with property rights, breach of contract, and libel are deductible from gross income. Damages of a personal character recovered against the physician, such as those for the surrender of the custody of a minor child, are not deductible from gross income because not related to the carrying on of the physician's profession.

Miscellaneous expenses which are incurred in producing taxable income and are allowable deductions include the following: fees paid to auditors, tax experts, and lawyers in connection with income tax matters, welfare work expense incurred in keeping up the morale in an organization.

(e) Informational Returns. All salaries, wages, fees, or other compensation for services actually rendered in connection with the physician's practice, including fees to independent contractors such as attorneys or accountants, which total or exceed $700 in the case of any individual recipient, must be reported or such expense shall not be deductible. This information, which must disclose the name, the address and the amount paid each such person, can either be furnished as a part of the income tax return or reported on form 9A, which form will be furnished the physician by the income tax assessor on request. Similar information must be furnished either on the return or on form 9A which should accompany the return, where deduction is sought on items of rent, royalty and interest expense.

REGISTRATION OF DEATHS

If you are not the attending physician at death but are subsequently called upon to determine the cause of death and file a death certificate, do not look for payment for the examination from public funds. Your fees for the examination are properly a part of the burial expense and your fee arrangement should be with the party responsible therefor. The only payment which can be made to you from public moneys is the usual 25 cent fee for filing the certificate which is paid by the county treasurer upon authorization of the local registrar.

It is especially important to remember this in the event you are asked to perform an autopsy not in conjunction with a coroner's inquest. There is no question as to whether you are entitled to a reasonable compensation for your services, but you cannot look to any state or local governmental unit for payment. See 30 Atty. Gen. 470. Be sure that you are properly authorized before proceeding with an autopsy. See "Coroners and Autopsies," page 112.

Estate and Inheritance Taxes

Introduction

ESTATES of sufficient size are today subject to at least two taxes during the course of probate. One is the federal estate tax which is levied on net estates in excess of $60,000. The second is the Wisconsin inheritance tax which is levied on each interest in excess of the statutory exemption which passes by reason of the death of an individual. These exemptions are in varying amounts, the largest being $15,000 in the case of a widow.

The above two taxes do not take into account the growing trend toward multiple taxation by which is meant the taxation of the same property by two or more states. This trend is checked as between states which have reciprocal statutes. Under the terms of such statutes multiple taxation is avoided by the provision that one state will not tax the property of a nonresident from a second state which in turn has a similar law. The problem is substantial to an increasing number of estates and can greatly reduce the provision which one has made for his family or other beneficiaries, where such person owns property in one or more states outside of Wisconsin which has no reciprocity statute. Such states reach out and tax whatever they can of the property of a nonresident.

The 1941 federal Revenue Act greatly increased basic estate tax rates with the result that those taxes at least doubled on the first $100,000 of taxable net estate. The 1942 act did not increase rates but did contain important amendments which will affect many estates hereafter. These amendments are summarized below.

Federal estate tax rates vary from 3 per cent to 28 per cent on the first $100,000 of net estate subject to tax, and increase by degrees to a 77 per cent maximum for that portion of any estate in excess of $10,000,000. It is reasonable to anticipate a reduction in the present exemption both for insurance and general assets, as well as a further increase in rates. Such changes may come within the next year. The increased rates have been effective since September 20, 1941, whereas the 1942 amendments hereafter discussed are effective only as to persons who died after October 21, 1942.

The only action of the 1941 Wisconsin Legislature with reference to inheritance taxes was the reenactment of the 30 per cent emergency relief tax computed over and above the normal inheritance tax. No other changes were enacted, and in consequence the tax liability of estates under the Wisconsin law remains what it was in 1940. The normal tax rate depends upon the relationship of the beneficiary to the deceased and upon the amount received, and varies from 2 per cent to 15 per cent of the amount over and above the exemptions given to the beneficiary. These basic rates are exclusive of the 30 per cent emergency relief tax which was reenacted as above stated. The legislature did not meet during 1942, and, accordingly, there were no changes in the 1942 rates or other provisions of the Wisconsin statute during the year.

Like other branches of tax law, those dealing with state inheritance and federal estate taxes are mounting both in their complexity and their rates. The points indicated below are not intended to be comprehensive or exhaustive, but rather to indicate to the physician, in broad outline, some of the general problems involved in those taxes, so as to aid him in planning his estate.

The subject of estate and inheritance taxes is treated in this issue because it bears with increasing directness on the long-term plans of the practicing physician. These taxes must be taken into account, for example, when a physician is making provision for the support of his family, the sale or other disposition of his practice, the collection of his outstanding accounts, and the termination of the partnership arrangement which he may have with one or more associates. The prudent practicing physician simply cannot disregard in these times the question of how his estate and his family will be affected by these taxes.

Closely related, of course, is the other problem of state and federal gift taxes, but since these deal with purely voluntary dispositions of surplus funds or other property, and are not, as such directly a part of the practice of medicine, that subject is not treated here. However, it is recommended that the physician ask his attorney to outline the problem of gifts and of gift tax liability for him, so that he may determine whether those laws have any special application to his personal situation.

Federal Estate Tax

The federal estate tax is based on the right of an individual to *give* away the property which he accumulates, as distinguished from the right on the part of his beneficiary to *receive* such property. Among the principal points of interest to the physician in connection with the federal estate tax are the following:

1. *Liability to file return.*—If the gross estate—that is, the total valuation of all assets before deducting debts, expenses of administration, taxes, etc.—is $60,000 or less, no estate tax return need be made by the executor or administrator of the estate of a deceased. If more than $60,000, such a return must be made.

2. *New Exemption of $60,000.* Until adoption of the amendments in October, 1942, the federal law has for a number of years provided an exemption of $40,000 of general assets which were not subject to estate tax and an additional $40,000 exemption of insurance payable to beneficiaries other than the estate of a deceased person. The 1942 amendment

repealed the insurance exemption and increased the general exemption from $40,000 to $60,000. This new exemption includes both insurance payable to the estate and insurance payable to beneficiaries other than the estate on policies on which the insured person has reserved the right to change beneficiaries, as well as other assets.

For the person who has little or no insurance, and whose estate consists of other property, the increased exemption will prove highly favorable. For the person who has $40,000 or more of insurance and in excess of $20,000 in general assets, the 1942 amendments will have the effect of increasing his estate taxes.

Example:

Valuation of gross general assets	$30,000
Amount of insurance payable to estate, or revocably assigned to others	45,000
Gross estate	75,000
Total of debts and deductions	10,000
Net value of estate	65,000
Amount subject to estate tax after deducting $60,000 exemption	5,000

3. *Powers of Appointment.* Each physician would do well at this time to read over his will and see whether it does not call for revision in the light of changed circumstances. One of the points to be noted particularly is the presence of a power of appointment in the will. By this is meant the conferring of authority on another person to designate the person or persons to receive certain of his property. By the terms of a 1942 amendment to the federal act all powers of appointment, except for those to very restricted classes of relatives, are taxable to the estate of the person to whom such power of appointment was given, *even though such latter person might himself have died without ever exercising the power.*

In other words, it is possible under the 1942 amendment for a physician by the phrasing of his own will to impose a heavy tax penalty on the estate of his wife, son, or anybody else to whom he may give a power of appointment, even though such wife, son, or other designated person never derived any benefit whatever from that power and never exercised it in his own favor or that of anyone else.

You should check this matter immediately with your attorney so that you may be sure to come within the exemption of the statute in the event you desire to continue the power of appointment in your will.

4. *Miscellaneous Amendments.* The 1942 federal amendments contain a number of other changes which may hold interest for the physician, one of which concerns charitable pledges founded on a promise or agreement to make a contribution or a gift, so long as the recipient is not an individual and is of a character recognized by the federal statute as being truly charitable. This would include such groups as churches, scientific and educational foundations.

Wills very frequently provide for a bequest of personal property or a devise of real estate to a certain person, under the further condition that if such person should die before receiving the gift, or should for any reason not accept the gift left him by the will, the property so given will go to a charitable organization. One of the new amendments provides that a person entitled to receive a gift by will may renounce or give up his claim irrevocably by a written statement filed prior to the time of filing the federal estate tax return, and that if he does so the property which he would otherwise have received is not subject to tax since it is to go to the charity rather than to him.

Still another of the new amendments provides that if an estate tax is not paid when due the wife or other beneficiary of the estate, including a person having the power of appointment, shall be liable for such tax to the extent of the amount of property which he has received from the estate.

5. *Irrevocably assigned insurance exempt.*—Insurance on the life of a deceased which was irrevocably assigned to beneficiaries other than his estate is wholly exempt from taxation if—

(a) The insurance was not assigned as a gift in contemplation of, or to take effect at, his death.

(b) The beneficiary paid the premiums on the insurance out of funds or his own which did not come to him from the insured either directly or by gift or trust established in his favor by the insured.

By the term "irrevocably assigned insurance" is meant the designation in a policy by the insured person of a person or persons as the beneficiaries of the policy without reservation in the insured of the privilege of changing the beneficiaries at any future date. This has the legal effect of vesting in the beneficiaries irrevocably designated all property rights to the policy.

A 1942 amendment provides that the possibility that a policy may come back into the hands of the insured person and be available to his estate does not destroy what is otherwise an irrevocable assignment.

6. *Joint interests taxable.*—Any property held by a physician and another, or others, jointly, is included in his gross estate to the extent of the physician's title or other interest in such property. Determination of the physician's *actual* interest where that varies from his *declared* interest is subject to technical rules which need not be detailed here. Thus if his *declared* interest as joint tenant in certain land acquired by purchase is shown by the deed to be one-third, whereas his *actual* financial interest is two-thirds, the land will be appraised in the inventory of his estate at two-thirds of its full value.

7. *New Accounts Receivable Rule.* From the standpoint of the physician one of the most important changes made by the 1942 Revenue Act was

the abolition of the accounts receivable accrual rule under which all the uncollected accounts receivable due a physician at the time of his death were given a valuation *both for income and estate tax purposes,* even though none of them were in fact collected at the time of his death, and part of them would never be collected.

The new change in the law provides that such accounts receivable shall not be accrued for income tax purposes at the time of death, but shall be treated as income when and as received by the estate or by some beneficiary of the estate. This is strictly a matter of income taxation, but because it is so closely linked with the cash provision which a physician must make when planning his estate, and because there has been confusion and misunderstanding in the past, the point is again emphasized here. It is treated more fully in the income tax article on page 61 of this issue.

It should be emphasized that for estate tax purposes a net valuation is *still* placed on the accounts due a physician at the time of his death, just as was true before. The important change is that the income tax on the accounts is payable *only as the accounts are received* instead of being payable by the estate during the course of probate *irrespective* of whether received or not.

Wisconsin Inheritance Tax

The Wisconsin inheritance tax is based on the right to *receive* property from the estate of a decedent in contrast to the basis for the federal tax, above noted, which is on the right to *give.* The practical effect of a tax on the right to inherit, such as Wisconsin's, is that each legacy or other share in the estate of a deceased is subject to tax to the extent that it exceeds the statutory exemptions, and the beneficiary gets only the net amount. Thus if a bequest of $5,000 is left by will to a beneficiary, and the inheritance tax on it is $300, such beneficiary will receive only $4,700 from the estate, the other $300 being retained for payment of the tax. This result can be avoided by provisions in the will that designated gifts are to be paid in their full amount to those designated, the estate to pay the amount of the tax. Below are indicated several points which it is hoped will assist the physician in estimating broadly his liability under the Wisconsin inheritance tax law.

1. *Liability to file return.*—Unless it is apparent from the final account rendered by the administrator or executor of an estate to the probate court that the estate is nominal in value, or that the net amount of any share of the estate will fall substantially short of the exemptions allowed by statute, as indicated in paragraph 2 immediately following, every administrator or executor must make an inheritance tax return to the state department of taxation.

2. *Tax exemptions.*—The following amounts received from estates are exempt: $15,000 received by a widow from the estate of her husband; $5,000 received by a widower from the estate of his wife; $2,000 where the relation of the beneficiary to the decedent is that of child, parent, brother, sister, descendent of brother or sister, daughter-in-law, son-in-law, or a child adopted under certain conditions. A $250 exemption is allowed where the relation of the beneficiary to the decedent is that of uncle or aunt or the descendent of an uncle or aunt. An exemption of $100 is allowed where the relation of the beneficiary to the decedent shall be that of any other degree than those stated above, or he shall be a stranger in blood to the decedent.

3. *Insurance exemption of $10,000.*—Under a 1939 amendment, insurance up to $10,000 on the life of a decedent, payable to a beneficiary or beneficiaries other than the estate of the insured is exempt from inheritance tax. This exemption is in addition to that allowed those same beneficiaries if they should receive any of the general assets of the estate, as indicated in paragraph 2 immediately above.

Each beneficiary of such insurance, other than the estate of the insured, is entitled to a portion of the total exemption of $10,000 based on the ratio that the value of the insurance payable to him bears to the value of the total insurance payable to all beneficiaries other than the estate.

Example: Dr. Smith dies and leaves $10,000 in insurance payable to his estate and a $10,000 policy to each of his five children, or a total of $60,000. The $10,000 policy payable to his estate is not included within the $10,000 exemption above, and may be disregarded for purposes of its computation; $2,000 would be exempt on each of the five policies of $10,000 to each of his children, and a tax would be payable on $8,000 of each of those policies. The $8,000 subject to tax in each instance would be added to any other share of such beneficiary in the general assets of the insured's estate and only one tax assessed.

4. *Insurance payable to estate nonexempt.*—No insurance payable to the estate of the insured person is exempt from the Wisconsin inheritance tax. It is included in the general assets of the estate, and whether a tax will ultimately be paid on it will depend entirely on whether the share going to each of the beneficiaries of the estate exceeds the statutory exemption.

5. *Irrevocably assigned insurance exempt.*—Insurance payable on the death of any person which is irrevocably assigned to a beneficiary other than the estate of the insured, so that the insured retains no legal incidents of ownership in such insurance is exempt from inheritance taxation. By "legal incidents of ownership" in an insurance policy are meant the right of the insured or his estate to its economic benefits, the power to change beneficiary, to surrender or cancel the policy, to revoke it for an assignment, to pledge it for a loan, or to borrow on it against the cash surrender value.

The exception to this general rule would be an irrevocable assignment of insurance made by the

assured in contemplation of his death, which would be included in his gross estate.

Further applying the statute, if an insurance policy were carried on Dr. Smith's life, even though his wife paid the premiums on the policy out of her own income, the face amount of the policy would be subject to state inheritance tax after the doctor's death, if he had during his life retained any of the "legal incidents of ownership" in the policy as that term is above defined.

6. *Joint interests taxable.*—Any property jointly held by the physician and another or others is subject to tax to the extent of the deceased's declared joint interest in such property.

Example: Dr. Smith and his wife own as joint tenants a farm worth $20,000 at the time of the doctor's death. Dr. Smith's interest is computed as one-half of that valuation, or $10,000, in his gross estate, and that amount will be deducted from the $15,000 which will be exempt in the hands of Mrs. Smith as his widow.

Agreements of Lease and Locum Tenens

THE negotiation and signing of leases is an almost universal periodic experience for the physician. If he will observe the precautions indicated below, he may avoid disagreeable experiences and monetary loss.

A. OFFICE LEASES

A lease is a special type of contract and once general negotiations have been completed, the desirable and prudent policy is to have an attorney draft the instrument itself. This will often prove a much more desirable policy than for the physician to read over hurriedly, and perhaps without full understanding, the printed provisions and rules of a "form" lease, which is generally drafted for the owner's protection rather than for that of the tenant.

The law on the subject of relation of landlord and tenant is a highly involved one and contains a large number of rules. It is thus difficult to generalize those rules, and the effort here made in that direction is intended to *indicate* problems which may quite commonly arise, together with suggested solutions. It must be borne in mind that the remedy in a given case may hinge on the particular facts, or even on a single fact, and that the suggestions above made will have general rather than specific application.

Important Lease Considerations

1. **Cancellation of lease by tenant for health or professional reasons.** The physician may wish to leave the community, in which he is practicing, for reasons of health or because of a more promising professional opportunity elsewhere. But because his office lease requires him to pay to the end of the term, and no other tenant can be readily procured, he may feel he cannot afford to leave.

Remedy: A clause giving the physician tenant the privilege of leaving for reasons of health, or for professional reasons, may be inserted in the lease with the consent of the owner. Ordinarily, such a provision requires the payment of some additional rent after the physician moves or gives notice of moving, say for thirty or sixty days ahead, so as to compensate the owner against possible vacancy for that period. The owner might reasonably require that in the event of removal for professional reasons, such change of location must not be merely to a place in the same locality, but some specified distance beyond the locality. This and details of notice and causes for moving should all be carefully agreed upon in such a provision.

2. **Cancellation of lease following death of physician.** The ordinary lease does not terminate on the death of the tenant but is expressly made binding on the tenant's heirs, personal representatives and assigns. This has the legal effect of binding the estate on rental and other obligations. It would seem wise to give the personal representative of a deceased physician (his administrator or executor) the option of limiting or terminating the rental liability of the estate whenever, in his judgment, this should be done.

Remedy: Following is proposed phrasing to carry out this suggestion:

It is mutually understood and agreed between the parties hereto, that in the event of death of the lessee during the term of this lease, his executors or administrators shall have the option of either terminating the lease or reducing its terms to a month to month rental basis, such privilege to be exercised within 60 days after the executors or administrators qualify as such in proper court proceedings.

Written notice of termination given to the lessor, or his agent, pursuant to the above agreement shall terminate all liability on the part of the lessee's estate, his administrators, executors or heirs, for rents to be paid for future occupancy of the premises beyond the 30 days next following the service of the notice.

Any option to renew contained in this lease may be exercised by the executors or administrators of the lessee at the time and in the same manner as provided for the lessee himself, but renewal of this lease will not be implied from any failure of the lessee's representatives to act hereunder.

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3. **Decorating of premises.** Unless a lease otherwise provides, the owner may not be obligated to do

any decorating of the exterior or interior of leased premises.

Remedy: Questions of decorating leased premises prior to occupancy and during the course of occupancy can easily be handled by appropriate provisions in the lease.

4. **Destruction of premises.** Leases frequently do not provide for the suspension of rent where fire or other casualty has rendered the premises partially or totally unfit for occupancy. Thus a situation may arise, in which the physician cannot continue to occupy the premises following a fire or other serious damage, or can, at best, only occupy them under great difficulty, and yet is compelled to continue full rent payments.

Remedy: The lease should provide that in the event the premises should become wholly untenantable by reason of casualty damage the physician either be immediately released from rental liability or be released following the expiration of a reasonable period required either for the rebuilding of the premises or for the substitution of office facilities in a form acceptable to him. Where premises have been made partially untenantable by reason of casualty damage the lease should provide for a proportionate abatement of rent. Thus if the premises are only 50 per cent usable, there should be a 50 per cent rental allowance until they are fully restored, but any percentage of nonuse over 50 per cent might well be considered as sufficient to excuse any rent payment.

5. **Heating and hot water facilities.** Unless a lease so specifies, the owner may not be obligated to furnish either heat or hot water, both of which are such essential items in a physician's office.

Remedy: Questions both of heating and the furnishing of hot water should be settled at the time negotiations are under way, and then should be carefully set out in the lease itself.

6. **Installations.** A physician may find that the premises he proposes to rent will require additional water and plumbing facilities, and also special gas and electric facilities. The three questions which arise in connection with such installations are: (1) Who has to pay for them initially? (2) Whose property do they become following installation? (3) Must they be removed or the premises restored at the termination of the lease? Such installations are generally costly, and these questions are therefore of substantial importance to the physician tenant.

Remedy: Wherever the plumbing, wiring, or other installations will permanently benefit the premises, the physician should endeavor to arrange that the owner pay so much of the installation cost as possible, and that he pay only the remainder. Wherever such installations are of such a character that they could be removed to other premises by the physician on the termination of his lease, he should reserve in himself the title to and right to remove such installations by terms of the lease itself. In the absence of such a provision, installations will ordinarily be regarded as affixed to the premises and, as such, a part of the real estate. This places title to such fixtures in the owner, and the tenant has no right to remove them on the expiration of the lease. Should the lease be for a period of only two or three years, a substantial investment would have been lost at the termination of that time should the physician be unable or unwilling to renew.

Where the tenant is permitted to remove such fixtures as he has installed, he would ordinarily be expected to restore the walls, floors and other affected parts of the premises to their original condition. This is a reasonable enough provision. Some leases, however, not only give the owner the legal title to such installed plumbing, wiring, etc., but also provide that at the owner's option the tenant may be required to restore the premises to their original condition on expiration of the lease, without being permitted to take away any of the fixtures for which he paid. The tenant should not permit such a provision in the lease.

7. **Miltary Service.** Until recently, the Soldiers' and Sailors' Civil Relief Act of 1940 did not extend its benefits to office space occupied by a person entering military service. Under the terms of an October 1942 amendment, the act has now been broadened to include space occupied for professional use. This point, which is of importance to every practicing physician who leases office space, is discussed on page 167 of this issue.

8. **Public liability coverage.** Many leases contain a clause under which the physician tenant assumes all liability which would normally accrue to the owner of the premises, as, for example, injury to a patient who might be hit by falling plaster in the physician's waiting room while keeping a professional appointment. The average public liability policy does not cover liability assumed under a contract by the tenant but, instead of this, commonly contains a clause substantially as follows:

> *"This policy does not apply to any liability assumed by the assured under any contract or agreement."*

The legal effect of such wording is that the physician is without protection under such a policy although he thinks he has coverage.

Remedy: First, examine the lease to see whether it contains such a provision; namely, that the physician tenant is responsible for any injury received by any person while on the leased premises, even though a defect in the building be its cause. Second, examine the public liability policy carefully. Third, if the policy contains an exclusion of any liability assumed by contract, the physician should then adopt one of the following two courses promptly: (1) arrange with the owner to change the lease provision under which he assumes such liability; (2) if he cannot have the lease modified, have the assumed liability covered by a specific endorsement to be added to the public liability policy.

9. **Renewal of lease.** No lease is automatically renewed unless it contains a specific renewal provi-

sion. All indications point to some increase in rental in the years immediately ahead, and the most practical way to hedge against increased rental is by timely provision in present leases or in leases which may hereafter be signed.

Remedy: If the physician is now under lease, it would be well for him to negotiate with the owner of the premises for a renewal option at this same rental. This provision could be added by mutual consent to the existing lease and would take effect on its expiration, if the option were exercised by the physician according to its terms. Ordinarily, such an option provides that the tenant may renew for an agreed period, at an agreed rental, by giving notice in writing of his intention to do so a certain number of days or months before the present lease expires. Those entering into leases hereafter would do well to include such renewal provisions.

10. **Repairs and upkeep.** The average responsible owner of office space will wish to keep up at least the exterior of the premises so as to prolong its life, minimize fire insurance rates and for other prudent reasons. Such owners are not necessarily willing to keep up the interior of the premises, however. Many leases go a step further and provide that all repairs of any nature which become necessary during the course of a lease are to be at the expense of the tenant. Thus, a physician might take over premises which were old or run down and have to replace such expensive items as the roof, floors, stairs, plumbing, heating plant and wiring during his occupancy.

Remedy: The prospective physician tenant should first make careful inspection of the premises he intends to lease, and come to immediate terms with the owner as to the condition in which they are to be put before he begins occupancy. He should then provide in the lease so far as possible that exterior repairs, such as painting, replacement of rotted boards or steps, or of the roof, be at the owner's expense. A still further provision might well be that repair or replacement of any substantial part of the premises during the lease was to be the obligation of the owner where such repair or replacement was due to ordinary wear and tear rather than to the negligence of the tenant. Still another prudent provision is that all structural repairs, which should include foundations, walls, floors, stairs, and roof, are to be the obligation of the owner rather than of the tenant. These provisions have particular importance where the physician is going to occupy old or outmoded premises.

11. **Subleasing.** Unless a lease makes provision for subleasing of the premises, the tenant has no rights whatever in this respect. A physician called into military service might find a highly desirable fellow physician to take over his practice, but he would be helpless in the matter unless the owner approved the subleasing. The same is true in the case of the physician who might wish to leave a community for reasons of health or because of an opportunity elsewhere.

Remedy: Provision should be made in the lease permitting subleasing of the premises after written notice to the owner. The provision permitting the physician to sublease should be as broad as possible, since he might not always be able to find a physician successor. At the very least it should permit him to sublease the premises to another medical practitioner.

B. LOCUM TENENS

In the case of many of the physicians called into the service of our country, the responsibility of continuing medical service for the community and of maintaining the professional establishment will be of major concern. The State Medical Society holds itself ready to be of assistance to its members in this problem at any time.

In those cases where a locum tenens is secured, the Society urges that the arrangements be confirmed by a written contract, drawn with the assistance of a local attorney. In arriving at the terms of such an agreement members should consider these fundamental points:

1. *Licensure.*—The locum tenens must be licensed in Wisconsin as one entitled to practice medicine and surgery, with his license filed in the county in which he resides. He should be a member of the local and State Society as a further assurance of his ethical standing and abilities.

2. *Staff privileges.*—Association on the hospital staff, where necessary, should be arranged. The locum tenens should be apprised of the conditions necessary to a continuation of this association, and his compliance with them should be a continuing condition of the contract.

3. *Malpractice liability.*—Malpractice insurance should be maintained by both parties under all circumstances.

4. *Partners, independent contractor, or employe.*—One of the most important matters for decision is that of determining the relationship under which the locum tenens is to assume management of the office. Your own attorney can best describe the practical aspects of this problem. It is sufficient to say that there is a real distinction between these with respect to liability of the principal party for the acts of the locum tenens, and with respect to his power to bind or otherwise obligate his absent confrere. In deciding this relationship, consideration must necessarily be given to the extent the locum tenens is to control the practice. For example, may he move the office acting upon his best judgment alone? Or may he make such purchases to the office account as his judgment dictates? Are the costs of operation to be a joint burden, and in any event, what are they?

5. *Financial arrangements.*—Whether the locum tenens is reimbursed on a salary or drawing basis,

arrangements must be made with respect to handling withdrawals, the financial records to be kept, collection policy and obligations of locum tenens with respect to accounts receivable of the physician. In this connection note "Fee Splitting," page 81, and particularly "The Amended Soldiers' and Sailors' Civil Relief Act," page 166.

Physicians and their attorneys are also referred to the article and opinions of the attorney general relative to division of fees between physicians, appearing on page 81.

6. *Locum tenens to give entire time.*—As an essential provision of the contract, provision should be made with reference to the amount of time that the locum tenens is to devote to the practice. Is he to give his entire time and not to engage in any business which would detract from his abilities to serve the community professionally?

7. *Costs of operation.*—If the salary or drawing arrangement with the locum tenens is to be based on the percentage of net income after payment of operating costs, items of costs should be specified so nearly as can be determined. If the physician should own his own office it is only proper that a rent basis for use of the office be established, and such items as light, heat, wages, insurance, supplies and equipment and the like should all be taken into consideration.

The physicians must likewise determine their policy with reference to accounting for collections for services rendered prior to execution of the agreement by the reserve officer. Are these to be considered income under the contract or are they excluded?

8. *Restriction on practice after termination of agreement.*—Wisconsin courts recognize the validity of clauses restricting practice after termination of a contract of employment. Your attorney may refer to the cases of *Eureka Laundry Company v. Long*, 146 Wis. 205, and *Madson v. Johnson*, 164 Wis. 612. The test is whether such a clause is in itself fair and reasonable and necessary for the proper protection of the professional interest involved. A frequent provision reads that the assistant may not maintain an office or hold himself out for practice in the city or within a reasonable area surrounding the city for a period of five years after termination.

9. *Arbitration of disputes.*—A clause may be inserted in the contract providing that in the event of disputes the matter may be referred to an arbitration committee of three, one to be selected by each party to the contract, the two so selected to select a third. The decisions of such an arbitration committee are ordinarily binding under the Wisconsin statutes.

10. *Termination.*—A provision for termination of the contract should be made. At the option of the party a definite date may be selected or termination can depend upon the time when the absent associate returns, or may be of indefinite duration, and terminable upon sixty or more days' notice. In any event it should be stated that failure on the part of the locum tenens to carry out in good faith the provisions of the contract should be cause for termination without notice.

11. *Miscellaneous matters.*—Other matters which a physician may desire to pass upon may include questions concerning the handling of bank accounts, power of attorney with reference to writing checks and the handling of certain business and personal matters of the absentee member, as well as the form of stationery, billing head, prescriptions, liquidation after termination of the agreement of accounts receivable arising during the operation by the locum tenens of the practice, care and replacement of medical instruments and the like.

* * *

The State Medical Society is most willing to cooperate with its members and their attorneys in the preparation of these contracts to meet the varying need of special circumstances and of the communities. If the physician is already in partnership, but a locum tenens is still necessary, the arrangement should be among all of the parties and the same applies even though the physician going into service is employed on a salary basis at the present time but wants to protect his particular practice.

LEGAL STATUS OF A POSTHUMOUS CHILD

For purposes of inheritance or succession a posthumous child is considered as living at his parent's death. Section 237.07, statutes. Any child born after the making of his parent's will shall have the same share in the estate of such parent as if the parent had died without a will where the will makes no provision for such afterborn child, unless it is apparent from the instrument itself that it was the intention of the deceased parent to make no provision for such child. Section 238.10, statutes.

When property is left by will to heirs, or issue, or children, posthumous children are entitled to take the same share in the same manner as if born before the death of the parents. Section 230.30 statutes. When a will provides that a gift of real estate or personal property depends upon the death of a person without heirs, issue, or children, the birth of a posthumous child will defeat the gift. Section 230.31, statutes.

Fee Splitting

BY STATUTE enacted in 1913, and strengthened in 1915, fee splitting by physicians is prohibited, even between physicians taking part in the same operation. *Each physician must render his bill direct to the patient.*

Shortly after the passage of this law, Attorney General Walter C. Owen, later a member of the Wisconsin Supreme Court, was called upon to give his opinion with respect to its interpretation and general effect. The important questions asked, and his answers are summarized below. For a more complete discussion see 3 Atty. Gen. 218.

1. *Under the law as it now stands, can a surgeon, not a member of the regular staff of a hospital operate at such hospital for a stated fee for the institution, and let the hospital collect the surgical fee from the patient according to his ability to pay along with other hospital fees; the hospital paying the surgeon the fee agreed upon, whether larger or smaller than the fee charged the patient by the hospital, or must the surgeon under the circumstances, charge the fee for the operation direct to the patient?*

While the law does not specifically make it an offense for a hospital to employ a surgeon who is not a member of its regular staff to perform a particular operation under an arrangement that the hospital make its charge to the patient for such operation or treatment and that it make its charge for such surgical services irrespective of the amount paid by it to the surgeon, yet it would seem that the evils incident to such a practice would be as great as in the case of fee splitting between two physicians or surgeons.

2. *Where a surgeon operates at a hospital in which he has a financial interest, or in which he is part owner or sole owner, but conducts the business in the name of the hospital, must he make a separate charge for operation or may the whole charge be made by and in the name of the hospital?*

The hospital may employ a physician or surgeon upon salary, and then make a contract with the patient to furnish him both medical or surgical treatment and hospital service. If this is done the entire charge could be made in the name of the hospital. If, however, the physician or surgeon is not paid a salary, but charges separately for each treatment or each operation, the safer practice is to make the charge for medical services direct to the patient and let the hospital make its charge separately to the patient.

3. *Can a surgeon who is not a resident of the city where the hospital is located and who does not hold himself out as a member of the staff of such hospital operate at such hospital and make a charge direct to the hospital under the existing law?*

4. *Where a country physician engages a surgeon to assist him in an operation at the home of the patient or at the residence of the country physician can the surgeon make his charge direct to the country physician engaging him or must he make a special contract with the patient?*

5. *Under these conditions can the country physician make the contract with the surgeon or must the contract be made directly with the surgeon by the patient?*

The attorney general's opinion answered all three of the questions with the statement that the safer practice under any of the above circumstances is for the surgeon to make his charge direct to the patient, or to phrase it otherwise, for the consulting surgeon to make a contract with the patient which is separate from that between the original physician and the patient.

6. *Is a physician who brings a patient to a hospital for an operation or to a surgeon for an operation entitled to a fee for assisting in such operation or for time spent in accompanying the patient to the hospital or place of operation?*

7. *Can a surgeon charge a regular fee for operations to a physician, including fee for operating room, dressings, anesthetic, etc., irrespective of the ability of the patient to pay, and the physician in charge of the case collect his fee, including such operating fee as he thinks right, the surgeon performing the operation doing the work for and on contract with the physician?*

8. *If the surgeon or hospital charges a regular fee for operation to physicians, must the same fee be charged to patients who come for operation not accompanied by their physician, or can the surgeon or hospital make a charge suited to the ability of the patient to pay?*

In each of these cases the attorney general answered that the physician's and surgeon's charges should be made *direct* to the patient, and that no part of the fee received by the surgeon or hospital should be paid to the physician advising the operation or treatment.

In 1935 the attorney general reiterated the conclusions given above in an opinion in 24 Atty. Gen. 580.

The practice of fee splitting has been widely criticized in the profession. For example, the American College of Surgeons has as a part of its requirements for the standardization of hospitals the adoption by each hospital of a resolution against the practice joined in by all physicians who have hospital privileges. Fee splitting is unreservedly condemned and a hospital in which this practice is known to exist cannot secure or retain a place on the approved list.

Malpractice and Malpractice Suits

THE Wisconsin statutes provide that complainants in personal injury actions must give notice of their claim within two years after the "happening of the event" causing the damage claimed, unless they have begun action by service of summons and complaint within the same period. Section 330.19 (5). The Wisconsin Supreme Court has held that no matter whether a cause of action based upon malpractice is predicated upon a tort (wrongful act) or contract (breach of agreement) liability, the action is essentially one for personal injury and falls within this particular statute. See Frechette v. Ravn, 145 Wis. 589; Klingbeil v. Saucerman, 165 Wis. 60. This is likewise true although the action may be one for loss of services, nursing and medical expense. See: Shovers v. Hahn, 178 Wis. 615. Our Supreme Court has also held that an infant is not excused from complying with this statute. Hoffmann v. Milwaukee Electric, 127 Wis. 76. Thus it follows that the provisions of the statute are applicable to individuals incapacitated by reason of insanity or a similar cause.

But if the statutory notice is given by those incapacitated by reason of infancy or insanity, the ordinary statute of limitations is extended. In the case of infants, the statute is extended until they reach the age of twenty-one years. If the individual is insane, the statutory period of limitations will be extended five years, unless he recovers within the six-year period. If he recovers after the ordinary period of limitations has expired but before the eleven-year period has expired, he must bring his action within one year after the disability ceases.

In order to protect himself properly in event of a malpractice claim, certain routines should be followed by every physician. (In this connection see also page 123 of this *Journal.*) These routines may avoid unmerited claims arising through misunderstanding or precipitated by some thoughtless remark. In *The Wisconsin Medical Journal,* 27:573–575 (Dec.) 1928, certain precautions were suggested, and their substance is restated and somewhat augmented here, to help in avoiding malpractice actions:

Causes For Misunderstanding

1. Medicine is a science but its proper application is largely an art. It is unwise to make unnecessary positive statements, particularly in early diagnosis or treatment in the broad field of human ills. When you say, "It is nothing but a cold; take these, go back to work and forget it," and subsequently it is found that the patient had incipient tuberculosis at the time he saw you, he is sure at least to resent your too-positive attitude if nothing more.

2. Few of the laity understand that an exact anatomical alignment in a fracture is not usual or necessary; that you are trying to attain it but that you are primarily interested in the functional result. When this is not explained and the patient subsequently sees an x-ray film showing only a fair anatomical result, who is to blame him if he fears he has had poor treatment? Frankness in explaining at least something of this to "fracture patients" is urged; then they will at least appreciate the difficulties that beset the paths of the best of men and will be thoroughly satisfied to find a good functional use restored.

3. The physician who promises quick results and fails to attain them frequently finds his patient seeking another physician.

4. Attorneys frequently say that street corner advice is worth just what one pays for it, yet it occurs with a fair degree of frequency that an attorney will ask a physician for street corner advice on a supposed course of treatment. Be careful what you say for he may be trying to arrive at conclusions whether a client has a real malpractice case. What he tells you will likely be but one side of the case and when all is known to you, your first opinion may be reversed.

5. In these days of compensation insurance a new cause for misunderstandings between physicians exists. It is an everyday occurrence for insurance carriers to demand that "their physician" see the insured. Reports are occasionally written by such physicians scoring the acts of the family physician. The insurance company may show this report to the claimant to show how his period of recovery was prolonged by faults of the family physician explaining that the company could hardly be expected to pay for that period. Again it is suggested that the second physician be sure he is in possession of all the facts before he scores the family physician. If he did his work carefully and exercised the same degree of skill as other practitioners in the community he will not be found guilty of malpractice even though a better treatment might have been had in a distant, large hospital with more adequate facilities.

6. When a patient does not pay his bill, and the ability to pay appears to exist, many physicians turn the bill over to a collection agency which may start suit in a physician's name. The man who does not pay his just debts within a reasonable period of time when ability to pay exists, is frequently not a man of honor or character. Such a man may bring a counterclaim alleging malpractice as a means of blackmailing the physician into dropping the original action for collection of fees. Indeed, records show a fairly large percentage of malpractice suits are begun as counterclaims rather than as original actions. The understanding physician, appreciating the danger in counterclaims on the part of the unscrupulous, will watch carefully that bills of such persons are not pressed unduly until after two years have passed following the last treatment. This generally

means an added delay of but a few months and is a wise precaution when dealing with the type of people mentioned. After two years malpractice is outlawed, but the statute of limitations still allows four years more in which to collect the debt.

7. No physician should pass over a case of definitely suspected fracture, dislocation or foreign body without advising roentgenograms to make certain the diagnosis, if it is impossible by the unaided senses to exclude these conditions. Failure to give such advice may lead to a malpractice suit.

8. The law does not require you to respond to a call by anyone who applies. But after you have once accepted employment, you assume responsibilities with respect to attendance that continue throughout employment. If you yourself desire to terminate those responsibilities, you may,—provided you give reasonable notice, in view of the condition of the patient, as will permit the patient to employ another attendant. This is a general rule of law; its applicability will vary as to each case.

Routine to Be Followed

Certain precautions should be followed as a routine if a physician desires to take every precaution to avoid malpractice actions.

1. Every roentgenogram should show the patient's number, the date, and at least the initials of the operator. The patient's record should show clearly the number of roentgen ray exposures.

2. In the case of fluoroscopic examinations the examiner should by all means note on the patient's record at the time the length in time of examination under the rays and the setting of the machine.

3. Do not put your faith in "fool-proof" apparatus. Have your equipment, such as your roentgen ray and fluoroscopic machines inspected regularly, for the assurance of the maker is no protection to you if something goes wrong.

4. Take no roentgenograms; do no fluoroscopic examinations without noting on the record the patient's statement as to when he was last exposed. If the patient is a "traveler" he may be burned through multiple exposures.

5. In fracture cases take a roentgenogram routinely on the day the patient is released. Besides providing you with the opportunity to explain functional versus anatomical results, you have evidence to prove the condition of the patient when released. Then if the patient has a subsequent accident he cannot substantiate a claim of non-union when released.

6. If your patient does not accede to roentgenography you have advised, or desires to leave the hospital before you think it wise, protect yourself against what might happen by reducing your advice to writing and handing a copy to the patient in the presence of at least one and preferably two witnesses. A written statement, signed by the patient in the presence of witnesses, refusing permission for use of roentgenography by you, or further hospitalization, is preferable. Following such procedure is of immeasurable value in event of future litigation.

7. It seems hardly necessary to state that in full records lies your greatest protection. Such records, made at the time, are the best evidence in court of conditions you found and treatment you advised. If your patient is not following your advice, be sure to make note of that at the time.

8. The importance of obtaining consent in all procedures involving operations or autopsies must never be overlooked. Neither good faith, patient welfare, nor good medical practices will stand alone as a defense against failure to secure consent, except only in those cases where an emergency makes it impractical for a physician to confer with the patient, or his guardian. See: Throne v. Wandell, 176 Wis. 97.

Burden that of surgeon.—While it is probably routine in all well regulated hospitals to secure a written consent from a patient about to undergo an operation, it must not be understood as any the less the surgeon's responsibility. And while oral consent is sufficient, difficulty of proof as to the fact that it was given condemns this procedure as insufficient protection.

Extent of consent.—A physician authorized to perform a specific operation acts at his peril in performing another or different one; nor, apparently, is he authorized to perform a more extensive and involved operation than that authorized. In all cases the consent should be sufficiently broad to include any procedures whether anticipated or not which may confront the surgeon at the time of operation. Consent must be obtained without fraud, and thus it is the safer policy to explain that sometimes unanticipated conditions or complications arise, so that, for the patient's welfare, the physician should be authorized to deal with them as they may arise.

Who may give consent.—Under ordinary conditions, and except in the emergency case as noted elsewhere, the person operated upon, if not a minor nor incompetent, may give his consent for any lawful operation. In the case of minors and incompetents, only those in the position of legal guardians are empowered to give such consent. The mere fact that a relative such as a brother endeavors to authorize an operation is insufficient, unless legal authority to do so exists.

Autopsy.—Consent is of equal importance where an autopsy is to be performed, and if it is desired to remove organs or specimens, the consent should so provide. The Wisconsin Supreme Court, in the case of Koerber v. Patek, 123 Wis. 453, held that—

> We can imagine no clearer or dearer right in the gamut of civil liberty and security than to bury our dead in peace and unobstructed; none more sacred to the individual, nor more important of preservation and protection from the point of view of public welfare and decency; certainly none where the

law need less hesitate to impose upon a wilful violator responsibility for the uttermost consequences of his act. We recognize, of course, that public welfare may and does require governmental control in many respects for protection of life and health of the people, and for discovery of crime connected with the death of a person, and to such interests the private right is subservient so far as necessary. Upon this ground rest cases of autopsies upon dead bodies under public authority, and to satisfy police regulations for ascertainment of cause of death.

Dr. W. C. Woodward, recently resigned director of the Bureau of Legal Medicine and Legislation of the American Medical Association, has pointed out that, subject to the legal rights of coroners, the right to control and custody of a dead body vests primarily in the surviving spouse, if there is any, and if not, in the next of kin in order of their consanguinity.

In the Koerber case, cited above, the Wisconsin Supreme Court also held that—

In absence of any surviving spouse, situations become subject to such complications that it probably is not wise, if proper, to attempt to declare general rules beyond the case actually presented. Suffice it to say that the duty and right of the parent toward the body of a minor child dying a member of his household, or of the adult child toward a widowed parent, either a member of the child's family circle, or not a member of any other, seems too clear to warrant discussion.

And while Wisconsin has not yet stated any further rules, Dr. Woodward suggests that as a practical matter: "Generally it will be found that some one of a given group will be at the place of death and will assume charge of the body, and it is to such a one that application will generally be made for permission to perform an autopsy. Almost universally, such consent is recognized as valid by other members of the group; but even if it should not be, the dissenting members would have difficulty in proving they had suffered damage by any supposed trespass on their rights."

However, it is only prudent to suggest that where there is doubt, great care should be exercised, and the advice of a local attorney sought. Even where the autopsy is performed at the request of a coroner, the physician is protected only when the coroner properly has jurisdiction of the body. Generally speaking, that means in Wisconsin either that the coroner must have ordered an inquest—on his own motion or at the request of the district attorney because there is good reason to believe that murder or manslaughter has been committed—before asking the doctor to perform the autopsy, or that a cremation of the body is planned and in the coroner's judgment an autopsy is warranted. When the physician is in any doubt as to the coroner's authority to authorize an autopsy, he would do well to check first with the district attorney and then with his own attorney on the question of the coroner's proper jurisdiction.

Character of suit.—Physicians generally understand that under the Wisconsin law, if a malpractice suit is not begun within two years after the happening of the event upon which the cause of action arose, proper notice must be given. The Wisconsin court has held that this is true whether the action be one in behalf of a minor, and whether based on breach of contract or negligence. But it is not clear whether the same law applies in the case of autopsies without consent. An action involving an unauthorized autopsy may be predicated differently, and not come within the statutory contemplation of an action arising out of a personal injury.

Other examinations; treatments.—It must be pointed out that many statutes come into play in connection with specific matters of examination and treatment. With these the physician is generally well acquainted. For example, authorization for treatment may be secured from the employer in workmen's compensation cases, but this does not release the patient's right to control, even though at some possible cost to himself, the question whether he shall or shall not receive some particular treatment. Yet even this may not be the right of the patient with venereal disease. The law becomes more complex, not more simplified, with the extension of legislative programs affecting the public security and welfare; but in all this the physician must keep in mind the general rules that govern the patient's welfare and his personal relationship to him.

For a more detailed treatment of the problem of consent to autopsies see the article entitled "Coroners and Autopsies," page 112.

9. If your operative reports are typed, read them carefully and sign your name in full. Do not just initial typed records. Never sign hospital operative records in blank to accommodate the hospital.

10. In the delegation of certain duties or functions to a technician, care should be exercised that such functions are those which may be called mechanical or ministerial and require the exercise of no judgment or discretion by the technician properly that of the physician.

The Case of Threat

Assuming that some day you are given a summons in a suit, or a suit is threatened, these pointers may be helpful:

1. Report the suit or threat to your insurance company *at once.*

2. You may be invited to call on the patient's attorney to "avoid" a suit. Let your attorney do that for you.

3. Tell your own attorney all the facts even though some do not reflect credit on your judgment. He cannot help you if you "hold out" on him.

4. Do not be offended if a friend of yours is going to testify for the plaintiff. Better a friend who will give you a square deal than a quack whose testimony is purchasable.

5. Be careful of too positive statements. Tell what you know in terms the jury can understand and admit that you do not know everything in medicine. When the plaintiff's attorney gets you to making one wholly positive statement after another he is soon apt to discredit your entire testimony by showing that authorities do not agree with some two or three statements and q. e. d.—you are "all wrong."

Malpractice Liability of Selective Service Examiner and of Physician in Service

A physician examining for a local selective service board and a medical officer in the armed forces of the United States is under legal duty to exercise the same degree of care, skill, diligence, and professional ability as would be expected of him in the care of patients in civilian life. The civil liability of a physician who acts for a selective service unit, or that of a physician in active military service, is in no way modified or diminished because his services may be performed or treatment rendered in connection with the defense needs of our government. This subject was well discussed in an editorial appearing in the September 13, 1941, issue of *The Journal of The American Medical Association*, which was in turn reprinted in the August, 1942, issue of *The Wisconsin Medical Journal* beginning at page 674.

The physician leaving for military service who is a member of a partnership, or who has made arrangements with some other physician to carry on his practice, should most certainly continue in force his malpractice insurance. His need for this form of protection is if anything greater during his absence.

As for the physician who has closed his office and made no arrangements for the continuation of his practice, the inclination may be strong to cancel his malpractice policy. However, this could be shortsighted economy, and it is recommended to the physician in the service of the armed forces of the United States that he continue his malpractice policy in force at all times. It is suggested that in any event a physician notify his insurance carrier of the fact of military service as soon as he enters upon active duty.

Every malpractice action undermines the confidence of the public in all physicians, and it is said that a dozen new suits are commenced based upon the publicity of a new case. You are your brother's keeper in maintaining a justified public confidence. Let no improper act of yours lead to a betrayal of that trust.

Summary of Wisconsin Poor Relief Laws Affecting Care of Indigent Sick

(For detailed treatment of subject see article in 1942 Blue Book beginning at page 1182).

THE 1942 Blue Book, published in the December, 1941, issue of *The Wisconsin Medical Journal*, contained a detailed summary of this subject which is of perennial importance to public health, to public administrators, and to the practicing physician. That article is not reprinted here, first, because there have been no legislative, judicial, administrative, or other important changes in the general law during 1942; and second, because the subject, momentarily at least, is less urgent than it has been at any time during the past decade. A marked reduction in the poor relief load has resulted from the heavy reemployment of men and women in connection with the greatly expanded productive requirements of our country during the present emergency.

Instead of summarizing the article of last year, there follows an enumeration, without discussion or explanation, of those principles of poor relief which have been enunciated by the legislature, the supreme court, and the attorney general of Wisconsin, and which hold some special interest for the practicing physician. Anyone interested in a detailed treatment should consult the 1942 Blue Book.

Wisconsin has had a poor relief law since it was admitted to statehood. Subsequent enactments, together with the judicial construction given the subject, have provided the legal framework for indigent needs in this state, and in particular for the indigent sick. It is on the administrative side rather than in the broad abstract concept of giving relief to "all poor and indigent persons," that never-ending problems have arisen such as legal settlement, authorization of relief, and the liability of some governmental body to provide care for the indigent sick.

By statute each town, village and city is required to relieve and support all poor and indigent persons lawfully settled therein, and this statute has been held mandatory. Ownership of property by persons seeking public relief does not bar the granting of relief where such person, by reason of unemployment, lack of available resources, or sickness stands in need thereof. The ownership of property goes only to the question of reimbursement of the municipality for relief given, and not to the basic question whether the person seeking relief is in fact without presently available means or credit with which to secure the necessities of life.

There is no "no-man's land" in matters involving relief. No matter if the applicant is working and is possessed of sufficient means to provide the ordinary daily necessities of life, if that individual has need of medical care for himself or family which he cannot himself secure, he is entitled to have the

assistance of relief officials. See: Coffeen v. Town of Preble, 142 Wis. 183. Thus it has been held the duty of relief officials to supply liver extract to one, suffering from pernicious anemia, whose means were insufficient to purchase that item, although sufficient for other purposes. See: 20 Atty. Gen. 162. In another case involving similar circumstances, the attorney general held the furnishing of insulin proper. See: 18 Atty. Gen. 8.

The responsibility of relief authorities to provide relief to those in necessitous circumstances is mandatory by statute and by decisions of the Wisconsin Supreme Court. See: Meyer v. Prairie du Chien, 9 Wis. 233; Elkey v. Seymour, 169 Wis. 223.

Failure of relief officials to render aid is misconduct for which they are "amenable in some way." Patrick v. Town of Baldwin, 109 Wis. 342. Unless the funds are insufficient, poor relief officials' wilful failure to care for a needy person subjects them to criminal prosecution as well as personal liability. See: 21 Atty. Gen. 1141.

The relief which the proper municipality is required to furnish must be coextensive with such person's necessities. Thus he may lack food, clothing, lodging, medical care, hospitalization, and medicine, or any one of these. *It is the duty of poor relief officials to furnish what the applicant lacks.* Thus a person may be medically indigent who is otherwise able to provide the ordinary necessities of life for himself and his family. If so, he is entitled to medical care.

There are three systems of administering poor relief. The first is the *unit* system under which each town, village and city relieves the poor within its respective boundaries; the second is the *county* system under which the county has charge of poor relief for all other municipalities within its borders; and the third is the system under which the county, by ordinance, assumes all sickness care, including medical and hospital aid, leaving all other poor relief on a local basis. Emergency medical relief and hospitalization may be authorized by any official designated for that purpose. Where no one is specially designated, the town chairman, village president, mayor, or chairman of the county board, depending upon the system in vogue in a given county, shall authorize such care.

Unless a poor relief or other official of a municipality has called in a physician to furnish professional care to an indigent, it is then the duty of the doctor to notify the proper authorities that such a person requires medical care, hospitalization, or medicine, as the case may be. If the municipality neglects in such a case to authorize such care, the physician is faced with the choice, except in an emergency, of remaining on the case with the chance that he may go without fees, or of withdrawing, and his conduct must be governed by the necessities of the case and medical ethics.

Where poor relief authorities have authorized a physician to treat a supposedly indigent person, the burden of proof is not upon the physician to establish that his patient was entitled to public aid, in order to collect his own fee. That duty rests upon the relief or other proper public officials.

With reference to fees for indigent medical care the physician will do well to bear in mind the following points:

1. It is desirable that the rate of charge, and if possible the fee, be specified at the time of authorization of services.
2. A physician's bill must be itemized and sworn to.
3. The physician's pay is *not* dependent on the results of his treatment.
4. The county or other relief unit is not liable for the malpractice of a physician who is paid by such unit.
5. A physician is not relieved of malpractice liability merely because he is engaged in furnishing professional services to the indigent sick at the request of a public official.

PHYSICIANS AND THE PHARMACY LAW

The sale, compounding and dispensing of drugs, other than narcotics, are governed by the provisions of chapter 151, Wisconsin statutes, entitled "Pharmacy." This defines the practice of pharmacy and sets forth the requirements of registration and other regulations of those who practice in this field.

The definition of "drugs" is very broad. Included are all articles intended for use in the diagnosis, cure, mitigation, treatment and prevention of disease, together with articles recognized in the official pharmacopoeias.

It is expressly provided in section 151.04 (3) that this chapter shall not interfere with the dispensing of drugs, medicines or other articles by physicians. The effect of this provision is that physicians are not governed by this law in so far as they dispense or compound drugs for their own patients or fill an occasional prescription for another physician. However, they must not fill prescriptions for others *as a business*. See 3 Atty. Gen. 555; 16 Atty. Gen. 722. A physician who desires to engage in the business of pharmacy must comply with the provisions of the pharmacy law just as must the pharmacist.

This chapter of the statutes has nothing to do with narcotic drugs, their definition or use. For information on this field see "Narcotic Laws," page 114.

Provisions of Wisconsin General Hospital Law

ACCORDING to the provisions of chapter 142 and section 36.31, Wis. Stats., the State of Wisconsin General Hospital, located in Madison, was established for two primary purposes: (1) to furnish facilities for teaching and the advancement of medical knowledge; and (2) to furnish specialized facilities for the care and hospitalization of patients lacking such facilities within their own communities.

142.01 **Public patients.** (1) A person having a legal settlement in any county in this state who is crippled or ailing and whose condition can probably be remedied or advantageously treated, if he or the person liable for his support is financially unable to provide proper treatment, may be treated at the Wisconsin general hospital or the Wisconsin orthopedic hospital for children at Madison or in such other hospital or rehabilitation camp as the county judge shall direct, except that when the person to be treated, or his guardian if he be under guardianship, shall select that such treatment be at the said Wisconsin general hospital or the said Wisconsin orthopedic hospital or rehabilitation camp, the hospital or rehabilitation camp of his selection shall be the place of treatment; provided that the right of such selection shall not exist in counties having a population of five hundred thousand or more . . .

142.02 **Application.** When the case of such person shall come to the notice of the sheriff, county supervisor, town clerk, health officer, health nurse, poor commissioner, policeman, physician or surgeon, or any public official, he shall and any teacher, priest or minister may, file with the county judge of the county wherein such afflicted person has a legal settlement an application for such treatment at such hospital.

The judge then appoints a physician to investigate the physical condition of the patient. At the same time the judge makes an investigation as to the propriety of such a commitment. The supervisor of the town, village or ward of residence of the person is required to furnish the court, upon request, with all material information within his knowledge in order that the judge may intelligently decide the case. If the judge is satisfied that the patient or the person liable for his support is financially unable to provide proper treatment and upon recommendation of the physician that the patient is a proper person for hospitalization at the State of Wisconsin General Hospital, the judge shall then issue an order approving such hospitalization, in which instance the cost is borne equally by state and county, provided that the county has not exceeded its quota for that year.

Unless the case is an emergency, the hospital desires the court order certifying the patient to the institution prior to the arrival of the patient. This allows the hospital to delay admission in certain cases where the services are already overcrowded.

Patients are also admitted to the hospital upon receipt of a letter from the family physician stating that the patient can pay $6 a day, in advance, for hospitalization, but that a professional fee or extras in addition would be a severe hardship. A few private cases are also admitted, but the hospital is not primarily interested in this type of work. Address all communications to the office of the Superintendent, 1300 University Avenue, Madison, Wisconsin.

Classification of patients admitted to the hospital, in 1940, is given below:

1. *County-state patient:* Hospitalization is authorized by the county judge of the county in which patient resides. Hospitalization costs are paid equally, half by the county and half by the state unless that county's quota for that year is exhausted in which case the county bears the full burden; (88 to 90 per cent of the patients in the hospital come under this classification).

2. *Special rate patient* (formerly called the "clinic case"): This type of patient comes to the hospital on his physician's recommendation that he be accepted on a $6 per day basis. A financial statement of the patient is taken on admission, and if it is felt that his status justifies a $6 per day charge he is admitted on that basis. He is thereby entitled to every service except transfusions and special nursing; (6 to 8 per cent of the patients in the hospital come under this classification).

3. *Private patient:* This type of patient is handled the same as would be the case in any other hospital *except* that he is accepted only on reference or recommendation of the physician in the home community.

No patient is accepted at Wisconsin General Hospital unless referred or recommended by the patient's physician, except in case of emergency or accident where delay may cause serious complications.

Divisions of Wisconsin General Hospital

Wisconsin General Hospital: Admissions per above; general hospital service plus teaching privileges in connection with the University.

Wisconsin Orthopedic Hospital: Orthopedic and plastic surgery patients only. All patients admitted through the regular admitting channels of the Wisconsin General Hospital. Crippled Children's Division secures admission for many patients through its services.

Wisconsin Psychiatric Institute: Furnishes facilities for blood and spinal fluid Wassermann examinations for the various state agencies and institutions, and for any physician desiring its facilities.

Bradley Memorial Hospital: This is a unit of Wisconsin General Hospital.

University of Wisconsin Infirmary: Student health center and hospital.

Scope and Fees

Provisions of the Wisconsin General Hospital Law as it relates to the relief of the medically indigent are contained in the "Summary of Wisconsin Poor Relief Laws Affecting Care of Indigent Sick," pages 85 and 86, and the purpose of this article is to treat particularly the extent of the law and the collection of physicians' fees allowed thereunder.

Treatment May Be at Home or in Local Institution

Under the Wisconsin General Hospital Law (sections 142.01 and 142.04) a person having a legal settlement in any county, who is crippled or ailing and whose condition can probably be remedied or treated advantageously, and for whom treatment is financially impossible, may be confined, as the situation warrants, in the Wisconsin General Hospital, in the Wisconsin Orthopedic Hospital, in a local institution or at home.

Limited Choice of Physician

A decision of the Wisconsin Supreme Court dated October 7, 1941, holds that under the present law an indigent patient cannot force the local relief unit to accept the physician chosen by him. In this case, entitled *Reissmann v. Jelinski*, 300 N. W. (adv. sh.) 164, the court emphasized that a county in furnishing relief under Chapter 142 may avail itself of the advantage to it in sharing relief costs with the state. The indigent had contended that although the county insisted that a needed operation be performed at the Wisconsin General Hospital, he could compel the county to authorize its performance by his personal physician at a local hospital.

The court recognized that under the law as it now stands the common practice of the local relief units is to select the physician regardless of the wishes of the indigent. His rights under the statute extend only to the furnishing of treatment, and the county has discharged its obligation when it makes treatment available to him. The question whether this is a desirable result was not discussed.

The point of the case is only that an indigent patient does not have free choice of physician, but there is nothing in the decision lessening the well established responsibility of a poor relief official to see that adequate medical care is provided for such persons. Chapter 49 is construed as a beneficent act, and under the provisions of 49.18 (2), the physician continues to have both the professional duty and statutory authorization to hospitalize an indigent patient when in his reasonable opinion "immediate hospitalization is required for indispensable emergency operation or treatment and prior authorization for such hospitalization cannot be obtained without delay likely to be injurious to the patient." In other words, patient welfare is still paramount and the wilful denial by the proper poor relief official of adequate medical care under all the circumstances of a given case is actionable both civilly and criminally. See 21 Atty. Gen. 1141, 1155.

Conditions Necessary to Local Treatment

Where treatment is to be given at home or in a local institution, the court must find that such treatment will be adequate and at the same or less expense to the county. But it must be kept in mind that the law is beneficent, and must be construed to give effect to its purpose. Thus the Attorney General has held that treatment need not be ordered at Madison in the emergency case, even though the expense might be less than in a local institution, because "it is not believed that the treatment at Madison would be considered adequate. . . ." (XXII Atty. Gen. 465). And in the consideration of "expense," the county judge may take into account the costs necessary to remove a patient to Madison, for transportation expense, and those of an attendant, both to and from the institution, are not items of joint state and county expense.

The County Quota

Under the provisions of the law, state aid ceases when the total county patients committed from any one county exceeds a ratio of more than two persons per thousand of population or major fraction thereof, although there is no limit if there is no hospital in the county concerned nor as to patients certified to the Wisconsin Orthopedic Hospital. The decision whether there is a hospital in the county is for the secretary of state at the time he certifies to the county its share of the costs. 30 Atty. Gen. 98. If the county exceeds its quota, then the county must pay the entire cost of hospitalization if the patient is to be confined in Madison. If the patient is confined at home under the provisions of the law no expense of hospitalization is involved at all. The only expense to the county would be that of medical care and nursing.

Physicians' Fees

In proceedings under the Wisconsin General Hospital Law, two entirely separate and distinct fees are permitted physicians.

By provisions of section 142.03 (2) the county judge, if satisfied that a patient presents a proper situation, "shall appoint a physician personally to examine the person." By statute, the physician is directed to make a verified report in writing giving certain required information, and shall "be paid by the county $5.00 and actual and necessary expenses." Since no method is provided for the payment of the physician, he must proceed through legal channels for the collection of the $5.00 fee allowed. Following the provisions of section 59.77 (1), dealing with claims against the county, the physician must make a statement of his claim in writing upon county voucher forms setting forth its nature and the facts

upon which it is founded. If the claim includes mileage, the statement should specify the days and places, so as to show between what points, and when, and the purpose for which the travel charges were made. Since the fee is statutory the time expended in the performance of service need not be stated. But the statement must be verified by affidavit and filed with the county clerk, whose duty it is, under the provisions of section 59.79 to transmit the same to the county board.

A further fee is allowable for medical treatment where a patient may be confined under the Wisconsin General Hospital Law in local hospitals or at home. Where such is the case, the county judge is required to "enter an order directing such treatment, the place thereof, and the physician or physicians." The expense of treatment of such patients, in local institutions or at home, shall be paid by the county treasurer, upon the certificate of the county judge who shall be satisfied as to the correctness and reasonableness thereof. The claim of the physician rendering the treatment need not be passed upon by the county board, but only by the county judge. See sections 142.04 and 142.08 (5). See also 21 Atty. Gen. 240 and 22 Atty. Gen. 408.

Treating the Sick in Wisconsin

Zealous in guarding the sick, and appreciative that the interest of the public health is always the foremost consideration, Wisconsin through its legislature and its courts has accepted the doctrine that to treat the sick is not a right but a privilege,—a privilege that must be guarded carefully in the interest of the public. The material presented here is particularly designed for the information of those seeking this privilege in Wisconsin, as well as to provide those who have already secured that privilege with basic information relative to their particular practice and its authorized scope.

For rules and procedure in filing application for licensure as prescribed by the State Board of Medical Examiners, physicians are referred to the secretary of the Board, Dr. H. W. Shutter, 425 East Wisconsin Avenue, Milwaukee.

THE BASIC SCIENCE LAW

General

IN 1925, at the request of the State Medical Society of Wisconsin, the Wisconsin Legislature enacted the Basic Science Law, being the first state to do so. The majority of the states now have laws similar in purpose and effect. The Basic Science Law, which is a part of Chapter 147 of the Wisconsin Statutes, is appropriately named because it enumerates not alone the basic qualifications imposed upon those who would treat the sick, regardless of their method or system of doing so, but because it is also the basic structure upon which the health laws of Wisconsin are predicated.

The Basic Science Law does not authorize one who has successfully passed the examination to engage in any form or manner in caring for the sick. The law is intended only to afford reasonable certainty that, in the basic sciences of anatomy, physiology, pathology and diagnosis,[1] those who treat the sick in Wisconsin possess the minimum qualifications.

The Basic Science Law provides that no person shall treat, or attempt to treat, the sick unless he has a certificate of registration in the basic sciences, recorded with the county clerk of the county in which he resides.[2] But this alone does not permit a registrant to treat the sick. He must be otherwise licensed.[3] No examining board for any branch of treating the sick may license, register or admit to its examination any applicant unless he first presents a certificate of registration in the basic sciences, with the exceptions noted in the paragraphs immediately below.

Specifically exempt from the operation of the Basic Science Law are commissioned surgeons of the army, navy and federal health service,[5] registered nurses,[6] dentists,[7] optometrists,[8] and persons practicing Christian Science or others administering to or treating the sick by mental or spiritual means.[9] Medical or osteopathic physicians of other states or countries in actual consultation with resident licensed practitioners,[10] persons gratuitously prescribing and administering family remedies or rendering treatment in an emergency are likewise exempted.[11]

The attorney general has ruled that masseurs are not required to qualify under this law, since their licensure provisions impose what amounts to a basic science examination in the limited field of practice of massage and hydrotherapy.[12]

All persons who, prior to February 1, 1925 (the effective date of the Basic Science Law), were not registered or licensed to treat the sick but, on that date, were lawfully treating the sick in Wisconsin

were granted the opportunity of being registered upon application to the board.[13] Thus, all persons lawfully treating the sick in Wisconsin, other than those above enumerated, must possess a basic science certificate or its equivalent.

Definitions of "Treating the Sick" and "Disease"

Section 147.01 (1), Wisconsin Statutes, 1941, defines what constitutes treating the sick in Wisconsin:

(a) "To treat the sick" is to examine into the fact, condition, or cause of human health or disease, or to treat, operate, prescribe, or advise for the same, or to undertake, offer, advertise, announce, or hold out in any manner to do any of said acts, for compensation, direct or indirect, or in the expectation thereof.

(b) "Disease" includes any pain, injury, deformity, or physical or mental illness or departure from complete health and proper condition of the human body or any of its parts.

Even such minor departures from complete health, as astigmatism, headaches and partial paralysis, constitute "disease" within the meaning of the Basic Science Law, and advising as to their care constitutes "treating the sick."[14] The use of roentgenography for diagnosis and treatment is treatment of the sick.[15] The use of natural forces, such as light, heat, air, water and exercise, in the treatment of disease, constitutes treating the sick within the provisions of the Basic Science Law.[16] Diagnosis and treatment of unhealthy conditions of the skin and scalp constitute treating the sick.[17]

Board of Examiners in the Basic Sciences

The State Board of Examiners in the Basic Sciences consists of three lay educators appointed by the Governor to serve for a term of six years each.[18] None of the appointees may be on the faculty of any department teaching methods of treating the sick.[19]

The board keeps a complete record of all applications, examinations, registrations, fees, decisions, orders and proceedings. It is authorized to appoint, subject to the civil service law, such competent and recognized experts as shall be necessary in examinations, as well as clerks. Their compensation, together with the compensation of board members, may not exceed in amount the fees received.[20]

Application for Registration

Application for a certificate of registration must be made to the Board of Examiners in the Basic Sciences. Such application must be accompanied by satisfactory evidence of good moral character and preliminary education equivalent to graduation from an accredited high school of this state, together with a fee of $10.[21] *The applicant is not required to disclose the professional school he attended or the system of treating the sick which he intends to pursue.*[22]

The preliminary high school requirement is waived only as to those applicants who were attending a professional school which was teaching the basic sciences on February 1, 1925.[23]

Basic Science Examination and Certificate

The examinations are conducted at least four times a year at times and places fixed by the board, and are both written and practical.[24] The applicant is examined in anatomy, physiology, pathology and diagnosis,[25] and if he achieves the grade of 75 per cent in each subject, he receives a certificate in the basic sciences signed by the president and secretary of the board. In the event the applicant fails in one subject only, he may be reexamined in that subject at any examination within one year without further fees, but if he fails in two or more, he must await the passage of one year, and must reapply and be reexamined in all subjects.[26]

An applicant seeking one of the limited licenses, such as for chiropody, need only state to the board that his practice is to be confined to one organ or set of organs, and his examination and certificate are limited accordingly.[27]

Since a certificate in the basic sciences does not authorize one to engage in the practice of treating the sick, compliance with the law is merely a condition precedent to taking the examination of one of the licensing boards. The Basic Science Law in no manner supplants conditions imposed by the various licensing boards.[28]

Reciprocity

The board may issue a certificate to an applicant who presents satisfactory evidence of having passed examination in the basic sciences before a legal examining board or officer of another state, or of a foreign country, if the standards are as high as those of this state, and upon the payment of a fee of $15.[29] This does not authorize the board, however, to accept the results of an examination conducted by the National Board of Medical Examiners in lieu of its own examination, for the reason that the National Board of Medical Examiners is a voluntary board as distinguished from a board created by law.[30]

Court Review

The applicant affected, or any state examining board for any branch of treating the sick, may commence action in the circuit court for Dane County against the board to set aside action by it either granting or denying a certificate of registration under the Basic Science Law. In such action the complaint must be served with the summons, and within twenty days the board must answer and file with the clerk of court the papers and records upon which it acted or copies thereof. The court must then try the issues upon such papers and records and such additional evidence as it in its discretion may decide upon. The court may then

dismiss the action, or remand the record to the board for further examination or investigation, or for modification or reversal of its action. In these actions the Attorney General appears for the board, and no costs are taxed by either party.[31] No such action has ever been instituted since organization of the board in 1925.

Revocation

A certificate of registration in the basic sciences is subject to revocation for the causes and in the manner provided in Section 147.20, Wisconsin Statutes.[32] For discussion of that section and procedure under it see "Revocation of License," page 92.

LICENSING REQUIREMENTS AND PROCEDURES

General

Under the provisions of the statutes, treating the sick is governed in the following terms:

147.14. Practice. (1) No person shall practice or attempt or hold himself out as authorized to practice medicine, surgery, or osteopathy, or any other system of treating bodily or mental ailments or injuries of human beings, without a license or certificate of registration from the state board of medical examiners, except as otherwise specifically provided by statute, nor unless he shall record the same with the county clerk of the county in which he resides and pay a fee of fifty cents for such recording. Nonresidents shall file such license or certificate in each county in which they shall practice. The clerk shall enter in a book kept for that purpose the date of the license or certificate, the name of the licensee, school or practice shown, and the date of the recording.

Several exceptions to this provision are created by virtue of a statutory provision that exempts those engaged in healing the sick through Christian Science or by mental or spiritual means;[33] while still another provision exempts from licensure requirements those engaged as commissioned officers of the army, navy, or federal public health service, or licensed practitioners in medicine and surgery or osteopathy and surgery of other states or countries who may be in actual consultation with resident licensed practitioners of this state. Nor does this law apply to gratuitous prescribing and administering of family remedies, or to treatment rendered in an emergency.[34]

Still others are exempt from the provisions of this section by reason of their compliance with other specific licensing statutes, such as those dealing with chiropractic and optometry.

However, there is no "No Man's Land" in licensure in Wisconsin. Specific theories or systems of treating the sick not recognized in Wisconsin *may not be pursued as a vocation.* This includes such cultists as naturopaths, naprapaths, and others. To treat the sick in Wisconsin, one must be licensed specifically to exercise that privilege under the Wisconsin licensure law.[35]

Each specific licensing field in Wisconsin is grouped under one of the several licensing boards. The State Board of Medical Examiners licenses applicants for the practice of medicine and surgery, osteopathy and surgery, midwifery, massage and hydrotherapy, and chiropody. Section 147.16 of the statutes states that all applicants in these several fields of treating the sick are to be given the same examination, so far as practicable, in the fields of anatomy, physiology, general diagnosis, pathology, histology, chemistry, hygiene and sanitation.

There are also licensing boards in chiropractic and optometry, dentistry and nursing. The latter two of these boards will not be discussed in this article, because each embraces a well defined and well regulated professional field, which does not call for extended comment here.

Licensure requirements and procedure, together with the powers of the respective licensing boards, will be treated in the pages following. As a matter of convenience for the reader, the licensing requirements and procedure for the several types of applicants will be summarized under the particular system of treating the sick, rather than by a classification of licensing boards.

Medicine and Surgery

Examining Board.—The examining body for applicants for license to practice medicine and surgery is the State Board of Medical Examiners, which is composed of eight licentiates, appointed by the governor for four-year terms.[36] No instructor, stockholder, member of, or persons financially interested in any school having a medical or osteopathic department, is eligible.[37] The board meets regularly on the second Tuesday of January at Madison, and on the last Tuesday of June at Milwaukee, and at such other times as are considered advisable. At the annual June meeting a president and secretary-treasurer are elected. It is the duty of the secretary-treasurer to receive for the board all money, and to pay it into the state treasury,[38] as well as to keep a record of its proceedings and a register of applications, licenses and certificates of registration issued.[39]

There is appropriated from the state general fund to the board for the execution of all its functions, all money received by it and paid into the general fund.[40] Of this there is allotted to each examiner not more than $10 for each day actually spent, together with actual and necessary expenses, to the board members.[41]

All applications for licensure from the State Board of Medical Examiners must be made to the board at the time and place designated by it, or at any regular meeting.[42]

Educational Requirements.—The applicant must have the three-year premedical course of the University of Wisconsin or its equivalent. Educational

requirements of applicants for license to practice medicine and surgery are summarized in Table 1, column 1, page 97.

Each applicant must also file with the board a verified statement that he is familiar with the state health laws and with the rules and regulations of the State Board of Health relating to communicable diseases,[43] satisfactory evidence of good moral and professional character[44] and proof of the fact that he is twenty-one years of age.[45] An applicant for license to practice medicine and surgery must also present a diploma from a reputable professional college approved and recognized by the board.[46]

The State Board of Medical Examiners has broad discretion in determining the reputability of professional schools,[47] and where it is impossible for the board to determine whether the college is reputable, the burden is upon the applicant to prove its reputability.[48]

In the event the applicant feels that the board was unjust in its determination that the professional school from which he was graduated did not meet its requirements, he may mandamus the board to grant him a license.[49]

Under no conditions or circumstances may the board issue a temporary license or certificate to an applicant in any system of treating the sick.

Examination and Licensure.—The State Board of Medical Examiners examines all applicants in anatomy, physiology, general diagnosis, pathology, histology, chemistry, hygiene and sanitation after first satisfying itself that all educational requirements have been met.[50] The board, by rule, may accept a basic science certificate in lieu of any examination in the fields of anatomy, physiology, pathology and diagnosis.[51] In addition to the uniform examination in the above subjects, the applicant is also examined by the board in such further subjects as are usually taught in a reputable medical school.[52] The board, if six of its members find the applicant qualified, then issues a license to practice medicine and surgery, signed by the president and secretary, and attested by the seal of the board.[53]

This license must be recorded by the physician with the county clerk of the county in which he resides, the recording fee being 50 cents. Nonresidents shall file such licenses in each county in which they practice. Until such license has been issued and recorded, no person may practice or attempt or hold himself out as authorized to practice medicine and surgery.[54] No person who is unlicensed, or who has not recorded his license as above provided, has the right to collect by law any compensation for professional services or to testify in a professional capacity, except in criminal actions, or under certain conditions, except for nonresident expert witnesses in medicine and surgery, or osteopathy and surgery.[55]

An immigrant applicant shall present satisfactory evidence of having first citizenship papers, and if his professional education was completed in a foreign college, the application shall be accompanied by a fee of $50. Any applicant who, by reason of his nationality, is ineligible to citizenship and who is a graduate of a reputable professional college in this country prior to the taking effect of the statute on February 1, 1925, and who has all other necessary qualifications, is issued a license if at least one of his parents was a native of the State of Wisconsin. Immigrant applicants also are required to pay the cost of translation into English by the board of documents and papers in a foreign language.[56]

Licensure without Examination.—The board may license without examination a person holding a license to practice medicine and surgery in another state, if in such state the requirements imposed are equivalent to those of this state, upon presentation of the license and a diploma from a reputable professional college approved and recognized by the board, or an honorably discharged surgeon of the army or navy, or of the federal public health service, upon filing of a sworn and authenticated copy of his discharge. The fee for license without examination shall be fixed by the board at not less than the reciprocity fee in the state whose license the applicant presents, but shall in no case be less than $50. A license from another state confers no privilege to practice in this state beyond the right to obtain a license by reciprocity in accordance with the statutes.[57]

Itinerants.—The following statute specifically governs licensure of the itinerant practitioner to practice any form or system of treating the afflicted:

147.18 Itinerants. Itinerant practitioners of medicine, surgery or osteopathy or of any form or system of treating the afflicted shall obtain an annual license in addition to the regular license or certificate of registration, and shall pay therefor two hundred fifty dollars per annum. Persons practicing medicine, surgery or osteopathy or professing or attempting to treat or heal ailments or injuries of the human body who go from place to place at regular or irregular intervals less frequently than once a week, are itinerant practitioners.

Revocation of License.—Three procedures have been established by statute for the revocation of a license or certificate issued by the Wisconsin State Board of Medical Examiners:

(a) By civil action

The district attorney is authorized to bring civil action in circuit court against the holder of a license to practice medicine and surgery and in the name of the state to revoke his license upon a verified complaint received by him charging the holder of the license with having been guilty of immoral or unprofessional conduct, or with having obtained a license by fraud, perjury or error.[58] The same subsection sets out certain other procedural features of such a suit.

The words "immoral or unprofessional conduct" are defined by section 147.20 (1), as follows:

(a) Procuring, aiding or abetting a criminal abortion; (b) advertising in any manner either in his own name or under the name of another person

or concern, actual or pretended, in any newspaper, pamphlet, circular, or other written or printed paper or document the curing of venereal diseases, the restoration of "lost manhood," the treatment and curing of private diseases peculiar to men or women, or the advertising or holding himself out to the public in any manner as a specialist in diseases of the sexual organs, or diseases caused by sexual weakness, self-abuse or excessive indulgences, or in any diseases of a like nature or produced by a like cause, or the advertising of any medicine or any means whatever whereby the monthly periods of women can be regulated or the menses re-established, if suppressed, or being employed by or in the service of any person, or concern, actual or pretended so advertising; (c) the obtaining of any fee, or offering to accept a fee on the assurance or promise that a manifestly incurable disease can be or will be permanently cured; (d) wilfully betraying a professional secret; (e) indulging in the drug habit; (f) conviction of an offense involving moral turpitude.

The license of a physician who attempts to perform an abortion may be revoked, and the fact that he was acquitted of the same charge in a criminal action does not bar a proceeding under this section.[59] Nor is the time within which to bring such action, after the offense has been committed, important.[60] The attorney general has further ruled that a physician who directed a patient to an abortionist who did, in fact, perform an abortion, is guilty, as an accessory before the fact, and his license is subject to revocation under this section.[61]

Subject to the limitation that any act in question must occur in the course of professional conduct, defrauding through use of the mails has been ruled to be a crime involving moral turpitude under section 147.20, while violation of the Federal Narcotic Act probably is not; indulgence in a drug habit is immoral or unprofessional conduct under section 147.20.[62]

(b) By action of the board

The statute also provides that when any person licensed by the State Board of Medical Examiners is convicted of a crime committed in the course of his professional conduct, the clerk of the court shall file with the board a certified copy of the information and of the verdict and judgment; and upon such filing the board shall revoke the license or certificate.[63]

The license of a physician who has been convicted of a crime cannot be revoked by the board unless the crime was committed in the course of his professional conduct. If the crime of which the person is convicted, however, involves moral turpitude, the license may be revoked by a circuit court action described in part (a) of this section.[64]

Revocation of a license under this section requires affirmative action by the board, and the right to practice continues until such action is taken.[65] There is no time limitation within which the board must act.[66]

The board has no authority to restore a revoked license.[67] It may be restored only after a first revocation, and then only by subsequent order of the trial court upon notice to the district attorney who prosecuted, or in the event of his disability, his successor in office, and upon written recommendation of the president of the State Board of Medical Examiners with a finding by the court that the applicant is of good moral and professional character and that justice demands the restoration.[68]

(c) State Medical Grievance Committee

In 1935 there was enacted the section quoted below.[69] It was designed to provide a body of qualified public officers to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery which are inimical to the public health.

The statute follows:

The state health officer, the secretary of the state board of medical examiners, and the attorney-general or deputy attorney-general are hereby constituted ex officio a state medical grievance committee, to investigate, hear, and act upon practices by persons licensed to practice medicine and surgery under section 147.17, that are inimical to the public health. The state health officer shall be chairman of the committee. Meetings of the committee shall be held at the call of the chairman. Any member thereof shall have power to subpoena and swear witnesses, and take evidence. The committee shall have power to warn and to reprimand, when they find such practice, and to institute criminal action or action to revoke license when they find also probable cause therefor under criminal or revocation statute, and the attorney-general may aid the district attorney in the prosecution thereof. The records of said committee shall be kept by and be in the custody of the chairman thereof. No member of said committee shall receive any extra compensation therefor, nor other than his actual expenditures in attending upon his duties thereon.

Osteopathy and Surgery

Examining Board.—The examining board for applicants for a license to practice osteopathy and surgery is the State Board of Medical Examiners, as in the case of applicants for license to practice medicine and surgery (See also page 1202).[70]

Educational Requirements.—These requirements are summarized in Table 1, column 2, page 97. Special attention is called to the 1941 amendment providing, in substance, that after June, 1948, an applicant must have had two years of college training, including physics, chemistry, biology and English, in an institution accredited by the University of Wisconsin.[71]

Examination and Licensure.—The board examines applicants for license to practice osteopathy and surgery in anatomy, physiology, general diagnosis, pathology, histology, chemistry, hygiene and sanitation, but by rule is also permitted to accept a basic science certificate in lieu of examination in anatomy, physiology, pathology and diagnosis.[72] An applicant must be twenty-one years of age, and must also file a verified statement that he is familiar with the state health laws and the rules and regulations of the State Board of Health relating to communicable diseases.[73]

In addition to the uniform examination in the above subjects, the State Board of Medical Ex-

aminers is further required to examine applicants in branches usually taught in a reputable osteopathic college.[74] It should be noted that the examination does not include materia medica, since applicants in the field of osteopathy and surgery are not trained in this field, as are graduates of medical colleges. If six members of the board find the applicant qualified, it then issues a license to practice osteopathy and surgery, signed by the president and secretary, and attested by the seal of the board.[75]

The license, as in the case of a physician and surgeon, must be recorded with the county clerk of the county in which the licensee resides, and a fee of 50 cents paid for such recording. Nonresidents must file such license in each county in which they practice.[76] The provision as to immigrant applicants to practice osteopathy and surgery are the same as those of an applicant to practice medicine and surgery. See page 92 and the statutory citation.[56]

Reciprocity.—The statutory provision relating to reciprocity where osteopaths are concerned is the same as that applicable in the case of physicians and surgeons. See "Licensure Without Examination," page 92.

Itinerants.—The statutory provision appearing under the title "Itinerants," page 92, also has equal application to osteopaths.

Revocation.—The same statutory authority, and in general the same case authority and attorney general's opinions having to do with licenses to practice medicine and surgery, have equal application to licenses to practice osteopathy and surgery. See "Revocation of License," page 92.

Chiropody

Examining Board.—The State Board of Medical Examiners, as earlier noted, likewise is the examining board for applicants to practice chiropody. See page 91, where the composition of the board is discussed.

Educational Requirements.—Educational requirements for applicants to practice chiropody are outlined in Table 1, column 3, page 97.

Examination and Certificate.—The statutes provide that the State Board of Medical Examiners shall select three registered chiropodists to conduct the examination under its supervision, one of whom is to be appointed as president, and another as secretary, of the chiropody examiners, all three to receive the same compensation as members of the board.

The examination is required to be both scientific and practical, to be written in English, and to cover anatomy and physiology of the feet, diagnosis of the foot ailments and deformities which the chiropodist is authorized to treat, materia medica, chiropodial orthopedics, bacteriology, pathology, histology, therapeutic chemistry, and minor surgery and bandaging pertaining to ailments of the feet, not including any amputation, and the mechanical treatment of congenital or acquired deformities of the feet. The written examination may be supplemented by oral and clinical examination.[77]

If the State Board of Medical Examiners finds the applicant qualified, it shall issue a certificate of registration which is required to be renewed on February 1 of each year upon application and the forwarding of a $2 annual renewal fee to the secretary of the chiropody examiners on or before January 31. Upon receipt of such application, the chiropody examiners are required to send the application fee to the State Board of Medical Examiners for renewal, and the statute levies a renewal fee of $7 against any chiropodist who fails to renew his application on or before January 31 of any year.[78]

The certificate shall be recorded with the county clerk of any county in which the holder practices.[79]

The Wisconsin statutes make no provision for immigrant applicants for a certificate to practice chiropody, nor do they contain reciprocity provision applicable to such individuals.

Itinerants.—The statutory provisions appearing under the title "Itinerants," page 92, have equal application to itinerant chiropodists.

Revocation of Certificate.—The statute provides that the certificate of registration may be revoked in the manner and for any of the causes set out in section 147.20 which is discussed on page 92. Among additional reasons for revocation of certificate is the failure to reregister before July 1 of any year or for "unprofessional conduct," which term includes the employment of solicitors to obtain business, obtaining fees by fraud or deceit, wilfully betraying professional secrets, and the like.[80] The penalties for violation of Chapter 154 relating to chiropody are set out in another section and include fine on the first offense and fine and imprisonment, or both, on a subsequent offense for persons convicted of fraud in connection with a chiropodist degree, practicing under a false or assumed name and similar offenses.[81]

Midwifery

Examining Board.—The examining board for applicants to practice midwifery is the State Board of Medical Examiners, and for general information on this body, its composition and general powers, see page 91.

Educational Requirements.—Educational requirements of applicants are summarized in Table 1, column 4, page 97.

Examination and Certificate.—The applicant is required to take a written examination in the anatomy of the female pelvis, anatomy and physiology of the organs contained in the female pelvis, symptoms, diagnosis, physiology and complications of pregnancy, diagnosis, course and management of labor, and care of mother and child for the first ten days.[82]

The examination is required to be prepared and conducted by three members of the State Board of

Medical Examiners appointed by the president, and if six members of the board find the applicant qualified it shall grant a certificate of registration, signed by the president and secretary of the board and attested by its seal.[83] The certificate should be recorded by the register of deeds of the county in which the midwife resides or practices, except that in Milwaukee she shall record the certificate with the registrar of vital statistics and pay 50 cents for such recording.[84]

The statutes contain no provision with reference either to immigrant applicants or the licensing of midwives by reciprocity.

Itinerants.—The general statute appearing under the title "Itinerants," page 92, has equal application to itinerant midwives.

Revocation of Certificate.—By statute, the provisions of section 147.20 which relate to revocation of license of physicians and osteopaths apply to midwives, except for the definition of "immoral or unprofessional conduct." This latter provision is defined by statute to mean in the case of midwives:

(a) procuring, aiding or abetting a criminal abortion; (b) advertising in her own or any other name in a written or printed paper or document in an obscene manner derogatory to good morals, or advertising means whereby the menses can be regulated, suppressed or reestablished or being in the service of anyone so advertising; (c) indulging in the drug habit; (d) conviction of an offense involving moral turpitude.[85]

Massage and Hydrotherapy

Examining Board.—The examining board for applicants to practice massage and hydrotherapy is the State Board of Medical Examiners.[86] For general information as to the composition and powers of this body, see "Examining Board," page 91.

Educational Requirements.—For educational requirements of applicants to practice massage and hydrotherapy, see Table 1, column 5, page 97. In spite of the positive statutory requirement that all persons treating the sick, unless expressly exempt, shall possess a basic science certificate in addition to passing successfully an examination given by the State Board of Medical Examiners in anatomy, physiology, general diagnosis, pathology, histology, chemistry, hygiene and sanitation, the Attorney General of Wisconsin has ruled that a basic science certificate is not a prerequisite to a certificate to practice massage and hydrotherapy, and that opinion has been followed in practice.[87]

The applicant also files a verified statement that he is familiar with the state health laws and rules and regulations of the State Board of Health relating to communicable diseases.[88]

Examination and Certificate.—The statute requires that the applicant be examined by the board in physiology, descriptive anatomy, pathology and hygiene, and that he be further examined in massage and hydrotherapy, under the supervision of the board by a registered practitioner selected by the board and receiving the same compensation as the board members.

If a majority of the board members find the applicant qualified, it shall issue a certificate of registration to practice massage and hydrotherapy signed by the president and secretary and attested by its seal, which certificate shall authorize practice in massage, hydrotherapy, and educational gymnastics, *but not the treatment of a specific disease except upon the advice of a licensed medical physician,* the latter being qualified to practice massage and hydrotherapy by virtue of his license without holding a certificate for the practice of massage and hydrotherapy.[89] The certificate should be recorded by the holder with the county clerk of the county in which he resides and a fee of 50 cents paid for such recording.[90] There is no provision in the statutes for licensing by reciprocity for the practice of massage and hydrotherapy.

Immigrant Applicants.—The provisions of section 147.15 of the Wisconsin Statutes relating to immigrant applicants to practice medicine and surgery or osteopathy and surgery are made applicable also to immigrant applicants for a certificate to practice massage and hydrotherapy. See page 92.[91] The statute contains no provision for licensing of masseurs and hydrotherapists by reciprocity.

Itinerants.—The general statute under the title "Itinerants," page 92, has equal application to itinerant practitioners of massage and hydrotherapy.

Revocation of Certificate.—The statutory provisions discussed under the title "Revocation of License," page 92, have general application to holders of certificates of registration in the field of massage and hydrotherapy.[92]

Chiropractic

Examining Board.—The examining body for applicants to practice chiropractic shall be the State Board of Examiners in Chiropractic, comprised of three chiropractors appointed by the Governor with the advice and consent of the Senate, who must have been continuous residents and practitioners of chiropractic in the state for the preceding three years, none of whom is an officer or employer, nor financially interested in any school or college of chiropractic, and none of whom is a graduate of any school teaching a method of treating the sick other than chiropractic. The term of office is six years, and a vacancy shall be filled for the unexpired term. Within thirty days after appointment, the board will meet for the election of a chairman and secretary. Members are compensated at the rate of $10 a day for each day actually spent, and for the actual and necessary expenses incurred in the performance of their official duties.

The board conducts examinations at least twice a year at such times and places as it determines.[93]

Educational Requirements.—Educational requirements for applicants for license to practice chiropractic are summarized in Table 1, column 6, page 97.

Examination and Licensure.—Applicants for license to practice chiropractic must first present a basic science certificate, and are then examined by the State Board of Examiners in Chiropractic, in subjects usually taught in reputable schools of chiropractic.[94] The statute also provides that all licenses issued by the board shall expire on the thirty-first of December following their issuance, except that any holder of a license may have the same renewed from year to year by payment of an annual fee of $5. Satisfactory evidence must be presented to the board that the holder of the license in the year preceding the application for renewal, has attended at least one of the two-day educational programs conducted, supervised and directed by the Wisconsin Chiropractic Association. Exemption from this latter requirement is granted only upon a showing satisfactory to the board that attendance at such educational program was unavoidably prevented. This annual education requirement has been ruled by the attorney general of Wisconsin to be constitutional.[95]

The license granted a chiropractic and his basic science certificate must be recorded with the county clerk of any county in which he shall practice or attempt or hold out to practice, and a fee of 50 cents paid for each recording.[96]

The statutes contain no provision with reference either to immigrant applicants or reciprocal licensing.

Itinerants.—The general statute dealing with physicians under the title "Itinerants," page 92, has equal application to itinerant chiropractors.

Revocation of License.—The statutes provide that licenses to practice chiropractic shall be subject to revocation for the causes and in the manner provided in section 147.20.[97] This section refers to revocation of licenses and certificates issued by the State Board of Medical Examiners, and is discussed under "Revocation of License," page 92.

Optometry

Examining Board.—The examining board for applicants for certificate of registration to practice optometry is the Wisconsin Board of Examiners in Optometry. It consists of five members appointed by the Governor for terms of five years each, each of such appointees to have been a resident of the state, actively engaged in the practice of optometry for at least five years immediately preceding appointment. The board chooses annually from among its members, a president and secretary, each of whom is empowered to administer oaths and take affidavits and to certify thereto under the seal of the board. The board meets at least once every six months at the State Capital, and on January 1 of each year reports its proceedings to the Governor, including an account of monies received and disbursed. The president and secretary also file annually with the Governor a verified list of optometrists qualified to serve as members of the board.[98]

Educational Requirements.—The educational requirements for applicants are summarized in Table 1, column 7, page 92. The supreme court has recognized optometry as a mechanical art requiring skill and knowledge, but not as a profession, although the fact remains that the conditions to which optometrists apply their skill constitutes "treating the sick" within the meaning of the basic science law.[99] That such was the conclusion of the optometrists themselves follows from the fact that they secured the introduction and supported a specific amendment to secure exemption from the effect of that law.[100]

Examination and Certificate.—The examination, which is not required of licensed physicians and surgeons, is by statute "confined to such knowledge as is essential to the practice of optometry" and includes anatomy, physiology, pathology of the eye and its appendages, normal and abnormal refractive, accommodative and muscular conditions and coordinations of the eye, and subjective and objective optometry including the fitting of glasses, the principles of lens construction and frame adjusting, and such other subjects as the board deems necessary. An applicant who fails at an examination has the privilege of taking another examination upon payment of a $10 fee at any future regular meeting of the board.[101] The board issues a certificate of registration to a successful applicant,[102] which is renewed on or before the first of January of each year on payment of a reregistration fee of $2.[103] Everyone practicing optometry is to display in a conspicuous place at the entrance of his place of business the name of each person so practicing therein.[104]

The holder of a certificate shall present the same or a certified copy to the county clerk of the county of his residence with a fee of 50 cents, and if he moves his residence to, or desires to practice in, another county he shall file a certified copy of the county clerk's record or a new certificate with the county clerk of such county with a fee of 50 cents for each recording before he practices in such other county. The board's fee for reissuance of a certificate is $1, and the county clerk's fee for certifying a record is the same amount. A certificate or certified record not recorded within six months after issuance is void.[105]

There is no provision in the optometry statute for the examination of immigrant applicants.

Reciprocity.—One who has been admitted to practice optometry in another state may be issued a certificate at the discretion of the board upon payment of $25 and production of a certificate showing that he has passed an examination in such other state and has actually practiced there for two years.[106]

Itinerant Optometrists.—The general statute under the title "Itinerants," page 92, has equal application to itinerant optometrists.

Revocation of Certificate.—The State Board of Examiners in Optometry may revoke a certificate

if the holder fails to pay the annual reregistration fee upon thirty days' notice of such proposed revocation. The board may revoke a certificate obtained through error or fraud, or where the recipient is grossly incompetent, guilty of immoral or unprofessional conduct, or has obtained or sought to obtain anything of value by fraudulent representation in the practice of optometry. The statutes also set out the procedure to be followed by the board in preferring charges against the holder of a certificate of registration, together with the procedure on appeal to the circuit court.[107]

One whose certificate has been revoked may have it regranted to him, after one year, upon application and satisfactory proof that the cause of revocation no longer exists.[108] "Unprofessional conduct," as that phrase is used in connection with revocation of a certificate of registration, is specifically defined by statute, and should be carefully read by interested persons. It includes any conduct of a character likely to deceive or defraud the public; price advertising on lenses or complete glasses; advertising free examinations; untruthful or misleading advertising; splitting or dividing with any person any fee for optometric services, and similar acts.[109]

A later section also holds guilty of unprofessional conduct any optometrist in the employ of a person who violates any of the provisions of chapter 153, Wisconsin statutes, relating to optometry, who, being given thirty days' notice by the board of such violation, continues in the employ of the violator.[110]

TABLE 1.—*Wisconsin Educational and Other Requirements Preliminary to Examination for License to Treat the Sick (Excluding Dentistry and Nursing)*

Applicant for License in	Preliminary	Undergraduate	Professional and Personal	Additional Requirements	Application Fee
1. Medicine and surgery (Secs. 147.15; 147.17 (1))	Equivalent to graduation from an accredited high school of this state.	Equivalent of 3-year premedical course at University of Wisconsin, including physics, chemistry, biology and either German or French.	Diploma from reputable professional college; good moral and professional character; applicant to he 21 years of age.	If not required by the professional school for graduation, internship of at least 12 months in a reputable hospital.	Not more than $20 with an additional $5 if license is issued.
2. Osteopathy and surgery (Secs. 147.15;147.17(1))	Equivalent to graduation from an accredited high school of this state.	After June, 1948, 2 years' college work including physics, chemistry, biology and English in an institution accredited by University of Wisconsin.	Diploma from reputable professional college; good moral and professional character; applicant to he 21 years of age.	None	Not more than $20 with an additional $5 if license is issued.
3. Chiropody (Sec. 154.02)	Equivalent to graduation from an accredited high school.	One year in a recognized college of liberal arts or science, since July 1, 1940.	Completion in a reputable school of chiropody, a course at least equivalent to 3 years of 37 weeks of 30 class hours each, in anatomy and physiology of the feet, and diagnosis of foot ailments and deformities which the chiropodist is authorized to treat, materia medica, chiropodial orthopedics, bacteriology, pathology, histology, therapeutic chemistry, minor surgery and bandaging pertaining to ailments of the feet and the mechanical treatment of congenital or acquired deformities of the feet. Applicant must he of good moral and professinnal character and more than 21 years of age.	None	$20
Midwifery (Sec. 150.02)	None	None	Diploma from a reputable school nf midwifery which is a school connected with a reputable hospital or sanatorium giving at least a 12 months' course in the science and practice of midwifery and practical experience in at least 20 cases; good moral and professional character.	None	$10 with an additional $5 if certificate is issued.
5. Massage and hydrotherapy (Sec. 147.185)	Equivalent to graduation from an accredited high school of this state.	None	Completion, in a scientific or professional school, of an adequate course in physiology, descriptive anatomy, pathology, and hygiene; good moral and professional character.	None	Not more than $20 with an nddtional $5 if certificate is issued.
6. Chiropractic (Sec. 147.23(3))	Equivalent to graduation from an accredited high school of this state.	None	Diploma from a reputable school of chiropractic, having n residence course of not less than 3 years, consisting of not less than 4,000 30-minute class hours; good moral character.	None	$25
7. Optometry (Secs 153.03; 153 .04)	High school education or its equivalent as determined by the board.	None	Attendance at an nptometry school fnr at least 2 years; not less than 2,000 hours actual instruction; or after nttending optometry school for 1 year shall have served as assistant to a registered optometrist for at least 2 yenrs, providing he has registered with the board when not less than 19years of age, as an assistant for nt least 2 years. Applicant must he 21 years of age to write examination.	None	$25 for application, plus $10 for exnmination.

Citations

Note: All references below, beginning with the abbreviation "Sec." are from the designated chapters and sections of the 1941 Wisconsin statutes. References containing the abbreviation "Wis." are from the designated volume and page of decisions of the supreme court of Wisconsin. References containing the abbreviations "Atty. Gen." are from the designated volume and pages of the official opinions of the attorney general of Wisconsin.

[1] Sec. 147.01 (1), (c).
[2] Sec. 147.02; 147.14 (1).
[3] Sec. 147.14 (1).
[4] Sec. 147.04.
[5] Sec. 147.02; Sec. 147.19 (1).
[6] Sec. 147.02.
[7] Sec. 147.01 (2).
[8] Ibid.
[9] Sec. 147.02; Sec. 147.19 (2).
[10] Sec. 147.02; Sec. 147.19 (1).
[11] Sec. 147.02; Sec. 147.19 (1).
[12] 26 Atty. Gen. 591, (1937).
[13] Sec. 147.09; 23 Atty. Gen. 87.
[14] Nickell v. State, 205 Wis. 614.
[15] 16 Atty. Gen. 560.
[16] 20 Atty. Gen. 107.
[17] 21 Atty. Gen. 1135.
[18] Sec. 147.03.
[19] Ibid.
[20] Sec. 147.12.
[21] Sec. 147.05.
[22] Sec. 147.06.
[23] Sec. 147.05; 22 Atty. Gen. 297.
[24] Sec. 147.06.
[25] Ibid.; Sec. 147.01 (1), (c).
[26] Sec. 147.07.
[27] Ibid.
[28] 26 Atty. Gen. 110.
[29] Sec. 147.08.
[30] 23 Atty. Gen. 303.
[31] Sec. 147.11.
[32] Sec. 147.10.
[33] Sec. 147.19 (2).
[34] Sec. 147.19 (1).
[35] Sec. 147.14 (1).
[36] Sec. 147.13 (1).
[37] Ibid.
[38] Sec. 147.13 (2).
[39] Sec. 147.13 (5).
[40] Sec. 20.44 (1).
[41] Sec. 147.13 (3); Sec. 20.44 (1), (a).
[42] Sec. 147.15.
[43] Ibid.
[44] Ibid.; State ex rel. Dubin v. State Board of Med. Exam., 222 Wis. 227, 223.
[45] Sec. 147.17 (1).
[46] Sec. 147.15.
[47] 19 Atty. Gen. 537; 25 Atty. Gen. 459.
[48] 25 Atty. Gen. 459; 26 Atty. Gen. 420.
[49] State ex rel. Blank v. Gramling, 219 Wis. 196, 204.
[50] Sec. 147.16.
[51] Sec. 147.04.
[52] Sec. 147.16.
[53] Sec. 147.17 (1).
[54] Sec. 147.14 (1).
[55] Sec. 147.14 (2).
[56] Sec. 147.15.
[57] Sec. 147.17 (1); 28 Atty. Gen. 685, 686.
[58] Sec. 147.20 (2).
[59] 12 Atty. Gen. 144; State v. Lewis, 164 Wis. 363.
[60] State v. Schaeffer, 129 Wis. 459, 467.
[61] 24 Atty. Gen. 108.
[62] 18 Atty. Gen. 289; 21 Atty. Gen. 476.
[63] Sec. 147.20 (3).
[64] 18 Atty. Gen. 289.
[65] 26 Atty. Gen. 378.
[66] 30 Atty. Gen. 43.
[67] 2 Atty. Gen. 571.
[68] Sec. 147.20 (4); 22 Atty. Gen. 942.
[69] Sec. 147.195.
[70] Sec. 147.14 (1).
[71] Sec. 147.15.
[72] Sec. 147.16; Sec. 147.04.
[73] Sec. 147.17 (1); 147.15.
[74] Sec. 147.16.
[75] Sec. 147.17 (1).
[76] Sec. 147.14 (1).
[77] Sec. 154.03.
[78] Sec. 154.04.
[79] Ibid.
[80] Sec. 154.05.
[81] Sec. 154.06.
[82] Sec. 150.03.
[83] Ibid.; Sec. 150.04 (1).
[84] Sec. 150.04 (2).
[85] Sec. 150.05 (2).
[86] Sec. 147.185.
[87] Sec. 147.02; Sec. 147.04; Sec. 147.16; 26 Atty. Gen. 591.
[88] Sec. 147.185.
[89] Sec. 147.185; 28 Atty. Gen. 685, 686.
[90] Sec. 147.14 (1).
[91] Sec. 147.185.
[92] Sec. 147.20.
[93] Sec. 147.23 (2); Sec. 147.23 (4).
[94] Sec. 147.23 (4).
[95] Sec. 147.23 (7); 24 Atty. Gen. 647.
[96] Sec. 147.23 (1).
[97] Sec. 147.23 (6).
[98] Sec. 153.02.
[99] State ex rel. Harris v. Kindy Optical Co. 235 Wis. 498, 501.
[100] Sec. 147.01 (2).
[101] Sec. 153.04.
[102] Sec. 153.05 (1).
[103] Sec. 153.05 (3).
[104] Sec. 153.05 (5).
[105] Sec. 153.05 (4).
[106] Sec. 153.05 (2).
[107] Sec. 153.06 (1), (2).
[108] Sec. 153.06 (3).
[109] Sec. 153.06 (4).
[110] Sec. 153.08.

BY-LAWS, CHAPTER VIII, SECTION 1

". . . Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted."

Legal Limitations on Licensure to Treat the Sick

ONLY persons licensed to practice medicine and surgery are comprehensively trained, and may use any modality they choose in the treatment of the sick. All other licentiates are limited in the scope of their practice.

Use of the Title "Doctor"

Section 147.14 (3), Wis. Stats., 1941, provides that:

No person not possessing a license to practice medicine and surgery, osteopathy, or osteopathy and surgery, under section 147.17, shall use or assume the title "doctor" or append to his name the words or letters "doctor," "Dr.," "specialist," "M. D.," "D. O." or any other title, letters or designation which represents or may tend to represent him as a doctor in any branch of treating the sick.

In addition to physicians and osteopaths, who are expressly mentioned in the above statute, only those licensed to practice dentistry, by virtue of express statutory permission, may use the title "doctor"[1] in the field of treating the sick.

The attorney general over a period of many years has ruled that the use of the title "doctor" alone, or in combination with any other phrase, whether modifying in character or not, is barred to all but those licensed to practice medicine and surgery, osteopathy and surgery, or dentistry. Optometrists, while not engaged in the practice of medicine,[2] are engaged in treating the sick, as they themselves conceded in asking to be excluded from the requirements of the basic science law;[3] the use of the title would effectively misrepresent their qualifications for they are but skilled tradesmen.[4] Chiropodists are entitled to use the designation "R. C.,"[5] but they are not "doctors." Masseurs are registered with the State Board of Medical Examiners and use the designation "R. M.," indicating that they are registered masseurs, but they are not "doctors," nor may they otherwise classify themselves.

The supreme court of Wisconsin has upheld numerous opinions of the attorney general ruling that the Wisconsin law forbids the use of the title "doctor" by chiropractors. In a recent opinion[6] by Chief Justice Rosenberry, the court held that such use:

. . . would tend to lead the public to the conclusion that persons so announcing themselves were qualified physicians, surgeons, or osteopaths as well as chiropractors. The situation is not aided because as was stipulated the defendant claimed he explained to his patient the nature of his treatment before administering it. *The title does not aid him in the treatment, it merely aids him in securing the confidence of prospective patients and in inducing people to apply for treatment* . . . (Italics ours)

Chiropractors

"Chiropractic" is defined as:

. . . The adjustment of, ordinarily, the spinal column, and ordinarily only by manipulation by the hand; also, that chiropractic does not include the use of any medicines or drugs, nor surgery, nor the use of any devices which do other than adjust, if, indeed, it permits mechanical apparatus even for adjustment.[7]

Chiropractors have advertised themselves as devoted to a theory that their practice is "a philosophy, science and art of things natural; a system of *adjusting* the articulations of the *spinal column, by hand* only, for the correction of the cause of disease. This definition is inclusive and any and all other methods are declared not to be chiropractic. All else belongs to other methods."[8]

Licensed only as chiropractors, the practice of these cultists is limited to chiropractic. This is a proper ruling, since to "permit them to do more than that is to turn loose a group of incompetents in the use of methods for which they are incompetent, and work a hardship on the public."[9]

Restrictions on Chiropractic Practice.—Chiropractors in Wisconsin are not available for the treatment of workmen's compensation cases, for a chiropractor "is not a physician as that term is used in the (compensation) act and in chapter 147."[10] One licensed only as a chiropractor in Wisconsin, who uses electrotherapy in the course of treatment violates the Medical Practice Act.[11] Nor can chiropractors administer medicines or drugs, nor use any therapeutic methods other than adjustment of the spinal column by hand.[12] Chiropractors are not privileged to disregard the quarantine of communicable diseases, as they are not physicians under the Wisconsin law.[13] A chiropractor is not permitted to perform electrocoagulation of the tonsils.[14] Not being a physician, he cannot sign death certificates,[15] or, by analogy, other health records.

Osteopaths

Osteopathy is frequently defined as a form of "manual treatment of disease." It is a system of therapy without the use of drugs, based on the theory that diseases are chiefly due to mechanical derangement in the structure of the human body, which can be remedied by manipulation.[16]

Applicants in this particular field, who demonstrate the necessary qualifications, have been licensed since 1916 to practice osteopathy and surgery. A person licensed before 1916 to practice osteopathy alone is licensed to practice surgery upon presenting satisfactory evidence of having completed the course in surgery at a reputable osteopathic college, requiring not less than twenty months' actual attendance, and the regular examina-

tion of the board in surgery, and upon being found qualified by six members of the Board of Medical Examiners.[17]

Under the accepted principle that osteopaths are licensed to practice only "osteopathy and surgery" and not "medicine and surgery," the attorney general has issued numerous opinions confining the practice of osteopathy to its own system or philosophy of treating the sick.[18] Thus it has been ruled by the attorney general that an osteopath cannot prescribe medicines except those necessary as a part of an actual surgical operation.[19]

Persons licensed to practice osteopathy and surgery may not enlarge the legal scope of their activities merely by undertaking to perform functions properly belonging to the practice of medicine alone. Since vaccination, and the use of serums, antitoxins and the like is a form of preventive medicine, an osteopath is forbidden their use in his practice, for, according to the attorney general, "The point is that if an osteopath is qualified to practice medicine he may become licensed to do so . . ."[20]

It follows from this line of reasoning that osteopaths, not being licensed to practice medicine, cannot give the "medical examinations" required in cases of admission to state sanatoriums and county tuberculosis hospitals,[21] nor can an osteopath certify to the Wassermann examination as required under the Wisconsin marriage laws.[22] Under a recent opinion of the attorney general, osteopaths may not give injections for arthritis, although they may administer rectal anesthetics, if licensed in surgery, in connection with an operation.[23]

Masseurs

One licensed to practice massage or hydrotherapy is authorized to practice in those two fields, or in educational gymnastics, but not to treat a specific disease, except upon the advice of a licensed medical physician.[24] Massage has been defined as "a system of remedial treatment consisting of manipulating a part or the whole of the body with the hands or by mechanical means," while hydrotherapy is the use of water for therapeutic purposes.[25] An opinion of the attorney general used the following definition: "a method of rubbing, kneading, or stroking of the superficial parts of the body by the hand or an instrument, for the purpose of modifying nutrition, restoring power of movement, breaking up adhesions, etc., and hydrotherapy is the treatment of disease by means of water."[26]

It has been held that one giving athletic rubs in a club in connection with athletics or physical exercise is not required to be licensed to practice massage or hydrotherapy as such a license is applicable only to the practice of massage for therapeutic purposes. The attorney general has more recently held, however, that a massage parlor for reducing purposes only must be operated by one licensed as a masseur.[27]

Midwives

A midwife is not authorized to use any instruments, except to sever the umbilical cord, and may not assist childbirth by artificial, forcible or mechanical means. The performance of version, removal of adherent placenta, is likewise forbidden her as is the administering, prescribing, advising or employing of any drug, herb or medicine other than disinfectant and ergot after redelivery of the placenta. A midwife is unauthorized to practice medicine, surgery or osteopathy, or assume any title or designation tending to show that she is a practitioner of medicine or by law so recognized or authorized to grant any medical or death certificate.[28]

A midwife is further restricted from giving prenatal care.[29]

Optometrists

The practice of optometry is the employment of any means, other than the use of drugs, for the measurement of the powers of vision and the adaption of lenses, prisms and mechanical therapy for the aid thereof.[30] It is a mechanical trade not a profession. The legislature "has dealt with optometry as a skilled calling, not as a profession involving a relation of special confidence between practitioner and patient."[31]

Chiropodists

The practice of chiropody permits the diagnosis or mechanical or surgical treatment, or treatment by the local application of drugs, of abnormal nails or superficial excrescences on the hands and feet, such as corns, warts and callouses, or fissures and bunions; the diagnosis or mechanical but not surgical treatment of congenital or acquired deformities of the feet, but *does not* include surgical operations upon the hands or feet for congenital or acquired deformities or conditions requiring the use of an anesthetic other than local. It *does not* permit incisions involving structures below the skin, nor of any portion or organ of the body above the feet, except that the diagnosis and mechanical treatment shall include the tendons and muscles of the lower leg in so far only as they are involved in the enumerated conditions of the feet.[32]

Enforcement

The 1941 Wisconsin Legislature transferred the obligation of enforcing the Medical Practice Act from the State Board of Health to the State Board of Medical Examiners.[33] An appropriation from the state general fund to the board will be made annually beginning July 1, 1941, to assist in financing the cost of this undertaking.

Anyone violating any provision of the Act "shall be fined not less than one hundred nor more than five hundred dollars, or imprisoned not less than sixty days nor more than one year, or both."[34]

Citations

Note: All references below, beginning with the abbreviation "Sec.," are from the designated chapters and sections of the 1941 Wisconsin statutes. References containing the abbreviation "Wis." are from the designated volume and page of decisions of the supreme court of Wisconsin. All references containing the abbreviations "Atty. Gen." are from the designated volume and pages of the official opinions of the attorney general of Wisconsin.

[1] Sec. 152.02 (1).
[2] State ex rel. Harris v. Kindy Optical Co. 235 Wis. 498, 501.
[3] Sec. 147.01 (1), (a), (b); 147.01 (2)
[4] State ex rel. Harris v. Kindy Optical Co. 235 Wis. 498, 501.
[5] Sec. 154.01 (2).
[6] State v. Michaels, 226 Wis. 574, 579, 580.
[7] 21 Atty. Gen. 646, 651; 29 Atty. Gen. 420, 421.
[8] Advertisement of Wisconsin Chiropractic Association, Appleton Post Crescent, October 6, 1931.
[9] Statement of B. J. Palmer, of Davenport, Iowa, founder of chiropractic, to the attorney general of Wisconsin, September 6, 1932.
[10] Corsten v. Industrial Commission, 207 Wis. 147, 148.
[11] 21 Atty. Gen. 646, 652.
[12] 29 Atty. Gen. 420.
[13] 7 Atty. Gen. 68, 69; 14 Atty. Gen. 442.
[14] 17 Atty. Gen. 318, 319.
[15] 16 Atty. Gen. 95.
[16] Herzog, Medical Jurisprudence, Sec. 121, and Arnold v. Schmidt, 155 Wis. 55, 61.
[17] Sec. 147.17 (1).
[18] 10 Atty. Gen. 837; 29 Atty. Gen. 148.
[19] 14 Atty. Gen. 231; 18 Atty. Gen. 6; 19 Atty. Gen. 594; 21 Atty. Gen. 137, 163.
[20] 29 Atty. Gen. 148, 153.
[21] Chap. 50, Wis. statutes, 1941.
[22] Sec. 245.10.
[23] 29 Atty. Gen. 420.
[24] Sec. 147.185.
[25] Herzog Medical Jurisprudence, Sec. 125, 128.
[26] 28 Atty. Gen. 685–686.
[27] 26 Atty. Gen. 61; 29 Atty. Gen. 297.
[28] Sec. 150.04 (3).
[29] 26 Atty. Gen. 236.
[30] Sec. 153.01.
[31] State ex rel. Harris v. Kindy Optical Company, 235 Wis. 498, 501.
[32] Sec. 154.01 (1).
[33] Sec. 147.13 (6).
[34] Sec. 147.21.

Legal Status of Internes and Externes

BEFORE discussing the legal status of internes and externes, it is first necessary to consider the definition of the terms, as used in Wisconsin. Little help in answering this question can be gained from the medical licensure act, chapter 147. The act makes no mention whatsoever of externes and only briefly refers to internes. The term "interne" is generally understood to apply to one who is engaged in a twelve-month's period of advanced study and apprenticeship immediately subsequent to the completion of his college course and prior to the granting of his license. Section 147.15 makes it a prerequisite for granting of a license to practice medicine and surgery. The term, however, is sometimes loosely applied to the second and third year following the completion of the required period of interneship, during which similar studies are continued. *But after the first year, unless his medical school requires a longer interneship as a condition of graduation, the interne must be licensed and have the legal status of a practicing physician.* The practical effect of the statutes is to recognize, as within a proper educational sphere, a requirement that a medical student must undertake an interneship as a condition of graduation, but at the moment that the educational requirement of interneship is satisfied the individual is thereupon subject to all the licensure provisions of the Wisconsin statutes. In this discussion then, "interne" will be limited to those in the first year of interneship.

The term "externe" is professionally applied to those advanced medical students *who have not as yet reached the interne stage, or been licensed to practice medicine,* but who are performing certain assisting and observing functions, either during a vacation period or during their fourth year of medical study, under the supervision of a licensed physician. Externes enter into this course of training under an arrangement between supervising physicians and the medical school. The hospital has no jurisdiction over them.

It is apparent then, that neither externes nor internes have the full legal status of licensed practitioners. Accordingly, the scope of their functions is correspondingly more confined. Their legal status has never been specifically passed upon by the courts, nor has the legislature seen fit to define their powers and duties, the matter being left entirely in the hands of the medical profession. That an interne has certain functions of a medical nature which he is permitted to perform is recognized by the Wisconsin Supreme Court, in the case of Nickley v. Eisenberg, 206 Wis. 265. The court there admitted that internes are not subject to the medical practice act, in that they may perform "such duties as are usually and ordinarily performed by them." It gave tacit recognition to the accepted practice performed by internes, pointing out that the legislature considered it essential to their professional training. In the same opinion, the court recognized the legal

status of certain nurses who were not registered under chapter 149. By the same reasoning, externes would probably have a recognized status in the medical profession. But their status is such that neither internes nor externes are within the provisions of the so-called "privilege statute" under the case of Borosich v. Metropolitan Life Insurance Company, 191 Wis. 239.

The further question arises as to those responsible for mistakes made by internes or externes while performing their customary duties. That they are personally responsible for their negligence, is, of course, conceded, and this liability may extend to physicians under whom they are working or to the hospital employing them. The law generally holds the interne to be an employe or servant, inasmuch as he is obliged to spend his days and nights at the hospital to render any administrative or medical service provided by the hospital through its agents within the range prescribed by propriety and custom. This interpretation of his position is recognized by the courts under the workmen's compensation act, which extends employe protection to internes injured in the performance of their duties in the hospital.

Wisconsin has held that the hospital is responsible for liability arising out of the acts of internes in the performance of duties which are customarily performed by them. Exemption, however, has been made in the case of charitable hospitals which are protected by law for the acts of their employes or servants. See Schumacher v. Evangelical Deaconess Society, 218 Wis. 169; and Kuglich v. Fowle, 185 Wis. 124. However, where the interne is acting under the direct supervision of a physician or surgeon during the course of an operation, the hospital is absolved from responsibility and his acts become those of the surgeon or physician who has charge of the work.

An externe, as was pointed out, is generally an assistant of a physician and has no relationship to the hospital. Because the duties delegated to an externe by a physician are generally very much limited, extending only to observation, a situation would seldom arise in which an act of an externe might cause injury. A physician would presumably have the duty to see to it that the externe be delegated no duty which would call for discretion or judgment on his part, but should he be negligent, the responsibility for his acts would doubtless be that of the physician.

Physicians and the Workmen's Compensation Act*

THE workmen's compensation act is designed to afford a measure of protection to the working men of the State of Wisconsin. The law, not applicable to farmers, affects employers who, in the course of a business, trade, profession, or occupation, usually have three or more employes. Benefits are provided an employe sustaining an injury or disease in the course of his employment. It has been stated frequently that all but the employer and the employe are strangers to the act and are unaffected by its provisions. Strictly, this is true. However, when a workman files a claim before the Industrial Commission alleging that he is entitled to benefits under the workmen's compensation act, the commission acquires functions that affect the relationship of the physician and his patient as well as the lawyer and his client.

As has been pointed out previously, many more physicians are constantly coming into contact with the procedures and practices of the Industrial Commission, and because inquiries are frequently directed to the State Medical Society regarding the act and the scope and effect of its provisions, this statement is prepared as a summary of some of the more important aspects of the law. While it has not been drafted by or at the suggestion of the Industrial Commission, it has been submitted to the commission and incorporated in it are the thoughts and suggestions of its staff members.

The panel system. Prior to the legislative session of 1939, the workmen's compensation act provided that employers of three or more employes could not be required to maintain a panel of more than five physicians from among whom the injured employe might make his choice of attendant. The panel must be furnished even though in some instances the only physicians available are not members of the State Medical Society of Wisconsin. The Society, in cooperation with associations representing both stock and mutual insurance companies writing compensation insurance in the State of Wisconsin, undertook to enlarge the panels through the voluntary cooperation of employers and insurance carriers, in an effort to give the workmen of this state an opportunity to secure virtual free choice of attendant. Through this cooperative effort approximately 80 per cent of the workmen of this state, subject to the compensation act, thus have available to them virtual free choice of physician.

In the 1939 legislative session, the statutory limitation as to the required size of the panel was repealed, and the Industrial Commission was given the authority to determine the proper size of the

* Reprint (with some corrections and alterations) of pamphlet issued by State Medical Society, June 15, 1940, to its membership. For much of the material the State Medical Society is indebted to Mr. Harry A. Nelson, Director, Workmen's Compensation, Wisconsin Industrial Commission.

panel through general orders or special orders applicable to given communities. But this amendment does not affect the agreement executed between the State Medical Society and the insurance carriers, under which a conference committee composed of both physicians and insurance company representatives was established. While the committee's responsibilities are manifold, it is important to the physicians who are members of this society that they may avail themselves of the services of that committee as an arbitration medium.

It is contemplated that the committee will function so as to reduce the differences that may arise between the insurance companies and the physician relating to the method of treatment of an injured workman, the charges made by the physician, and similar questions. Conversely, the insurance companies have the opportunity of referring to the conference committee for arbitration situations in which insurance company officials may be of the opinion that the physician's charges have been excessive or in which the physician has neglected to supply the company with the information to which it is properly entitled.

No formality is required in the cases where either the physician or the insurance companies may have a matter to report relative to the handling or disposition of compensation cases. The secretary of the State Medical Society should be informed of the general nature of the complaint and further information, if necessary, will be acquired that the committee may function to the best advantage possible.

While the committee does not meet regularly, its meetings are comparatively frequent, and questions of policy and of the application of the workmen's compensation act are being continually referred to it.

Under the law, of course, the employer is required to post the panel physicians available for treatment just as it is primarily his duty rather than that of his insurer, if he has one, to provide medical care. If the employer fails to do this, the effect of certain supreme court opinions is to hold that the injured workman has absolute free choice of physician. The medical panels of those employers whose insurance is carried by insurance companies participating in the open panel agreement with the State Medical Society are made up only periodically and so far it has not been necessary to revise these oftener than once each year. A physician who desires to participate in panel listing and who is not now listed may apply to the Society. In applying to the Society, the physician agrees that if he is listed on the panel and engages in treating compensation cases, he will call a consulting physician into the case upon request of the insurance carrier. It is expected that the physician will communicate with the insurance carrier as to the choice of consultant.

The members of the State Medical Society should keep in mind that the effort of their society and the insurance carriers is to provide physicians able and willing to treat compensation cases and to assure to those workmen entitled to the benefits of the act what amounts to a free choice of attendant.

Benefits of the act. The workmen's compensation act is an attempt to provide injured employes reasonable recompense for injuries or diseases received during the course of their employment and to provide them with such medical attention as may be necessary to accomplish the utmost in rehabilitation. The law imposes a liability upon the employer to provide certain indemnities and to provide or pay for necessary medical attention. Because it is in the nature of a liability, those concerned with the compensation act, while they are liberal in its construction, must find three essential elements to exist in order to justify an award to the injured claimant: (1) employer-employe relationship; (2) employer subject to the act; and (3) injury or disease suffered or acquired in the course of employment. With reference to medical care, the workmen's compensation act provides that employers subject to the act must supply any injured employe with "such medical, surgical and hospital treatment, medicines, medical and surgical supplies, crutches, artificial limbs and appliances . . . as may be reasonably required to cure and relieve from the effects of the injury, not to exceed the period for which indemnity is payable . . ."

Collection of physician's account. It is important to keep in mind that there may be one of two, or two, sources from which the physician may be paid for his services rendered an injured workman entitled to benefits under the act. If the employer himself authorizes the physician to treat the injured workman, then the employer is directly liable to the physician for the expense of that treatment, and that liability continues until such time as it is terminated by the employer's objection to further medical care at his expense.

If, on the other hand, the injured employe himself requested the treatment, without authorization from the employer, then the physician must look to the injured employe for payment, except ordinarily he can expect the Industrial Commission to determine the amount thereof for which the employer is responsible. Where the employer fails to furnish a panel, the injured employe has complete free choice, and the Industrial Commission has power to determine the reasonable necessity for treatment and the reasonable amount of the medical bill for which the employer is responsible. In cases where the employe has not given notice of necessity for treatment or has refused to accept a panel physician, the employer has no liability and the commission no jurisdiction to determine necessity or reasonableness but does, upon claimant employe's request, direct payment to the physician of what appears to be a reasonable amount for necessary treatment.

Physician-patient relationship maintained. Generally, of course, communications to an attending physician are privileged and may not be communicated by him. The workmen's compensation act creates an exception to the general law of privilege as any physician, having attended an injured employe who files a claim under the workmen's compensation act, may be required to testify before the Commission when it so directs. With reference to this the Commission says: "It is a practical necessity that the physician attending the injured workman furnish information to the Commission upon which to base compensation. Physicians will not be required, however, to disclose confidential communications commuted to them for the purpose of treatment and which are unnecessary to a proper disposition of the claim. The Commission regards the physician who treats the injured workman at the request of the employer, to all intents and purposes, the physician of the injured man. His testimony before the Commission should be absolutely fair and unbiased."

The physician acting as expert witness for injured claimant. Not infrequently, of course, the claim of an injured workman that he has suffered injury in the course of his employment for which he is entitled to compensation is disputed by the employer or the compensation carrier of the employer. The members of the State Medical Society have no interest, of course, in the technical questions of fact and law which involve other than medical questions. They are interested, however, (regardless of whether they may be the attending physician or an expert witness for either the injured workman, or the employer or his insurance company) in the fact that the basis of any claim must depend upon whether the injury or disease was suffered in the course of employment.

In many cases the fact of the injury or disease being suffered in the course of employment is accepted by the employer or the insurance company and the question then is confined to the extent of liability on the part of the employer. In the fields of industrial disease, or diseases attributable to a given occupation, the physician must be prepared to relate the disability to the employe, if such be the case.

Where the claim is controverted by the employer or insurance company either as to causative factor or as to extent, the injured workman frequently calls upon a physician other than the attending physician to appear as an expert witness in his behalf. In such case, the physician must make a careful study and examination of the whole question and be prepared to present his opinion adequately and carefully.

The State Medical Society has received many inquiries raising the question of how the expert witness is paid and to what extent. Before discussing this question in its many implications, certain basic concepts of the workmen's compensation act must be kept in mind. Of primary consideration the claimant must first establish: (1) the employer-employe relationship with both employer and employe subject to the act, and (2) the fact of an injury or disease sustained or acquired by the claimant in the course of such employment.

Second, as stated elsewhere in this memorandum, the employe is entitled, in event of injury and an award therefor, only to recompense for the injury and for the cost of treatment. The award may not be frivolous or capricious and is governed by the strict formula provided in the act itself. The award, or the jurisdiction to grant one, does not involve the unlimited field of a personal injury action but is strictly governed by statutory limitations.

In the third place, it is conceived as the function and responsibility of the Industrial Commission to protect the injured claimant in every proper way. For example, the law does not provide that applicants be represented by attorney in hearings before the commission, but that they may appear in person or by agent. When they appear without attorney, the commission undertakes to do everything possible to assure a fair and impartial hearing. By statute, furthermore, the Commission has authority to determine the reasonableness of attorneys' fees rendered by attorneys representing the claimant. By express provision of law, it is illegal for an attorney to charge in any case more than 10 per cent of the award on a contingent basis or a maximum of $100, unless the Commission has first authorized such a charge. The Commission is authorized, in the interest of a fair and impartial hearing, to order examinations by physicians who are wholly independent of either the claimant, the employer, or the insurance carrier. Such physicians become witnesses of the State of Wisconsin at the time they appear to testify relative to the claim of the injured workman.

Finally, the Commission directs attention to the case of Philler v. Waukesha County, 139 Wis. 211, to the effect that expert witnesses may not require payment in excess of statutory fees unless work is performed in preparation at the request of a party. The question frequently arises as to whether a physician must obey a subpoena when ordinary witness fees only are paid. Many physicians believe that they cannot be required to do so unless an expert witness fee is paid to them. Our court, however, has held that except as there may be a demand for preparation, etc., every witness, whether expert or otherwise, must obey a subpoena upon payment of ordinary witness fees.

Because it so frequently deals with the question of physicians' fees, both those in connection with treatment in the case or as an expert, the Commission and its staff tend to establish certain levels in the professional work of such physicians. In the case of physicians who are called by the Commis-

sion as independent expert witnesses or for the purpose of simply making an examination and report, the Industrial Commission has an established fee schedule under which the services are rendered. This fee schedule is set out under rule 13 and is as follows:

"Unless otherwise specifically agreed, services of physicians and surgeons rendered at the request of the Commission shall be understood as contracted for on the following terms:

Minor examination and report, not to exceed	$ 5.00
Major examination and report, not to exceed	10.00
X-rays where necessary to foregoing examination and report, not to exceed an additional	5.00
Attendance at hearings on request of Commission:	
for first hour	10.00
for each additional hour	5.00

Claims for such services must be paid from the Commission's appropriation and should be submitted on official voucher blanks."

These fees do not, of course, govern the contractual relation between the physician and the claimant, and the physician and the employer, where the physician is called as the expert witness of either. But in those cases in which the physician appears as an expert witness for the injured employe, and seeks to have his fees paid directly out of the compensation award, it must be expected that the Industrial Commission will endeavor to protect the employe through permitting only what it considers to be a reasonable allowance for the expert. Each bill necessarily depends on the circumstances of the individual case, but the State Medical Society suggests to its members the practical necessity of submitting itemized statements substantiating the charges made by the expert witness.

With an itemized statement before it, the Industrial Commission is in a better position to judge of the work involved and of the reasonableness of the charges of the physician. While it is true that the Industrial Commission is undoubtedly influenced in establishing the fee schedule for expert witnesses of the state by the fact that payment of these experts is from state funds, yet it seems obvious that such a fee schedule is, in the opinion of the Commission at least, generally reasonable.

In the case of state employes who file compensation claims, the Commission is explicit in its demands for itemized medical statements and for verification of the reasonableness of the charge:

(Rule 18)

"No claim for compensation or medical aid by an employe of the state will be allowed until the following reports and statements have been furnished to the Commission:

"(2) A sworn statement by the injured employe to the effect that he was injured in the course of his employment and reciting the time and place of the injury, the reasons for its occurrence, and the nature of the injury, and also setting forth *in detail* the expenditures incurred for necessary medical, surgical and hospital treatment and medicines, (if these bills were paid by the injured, receipts must be attached) . . .

* * *

"(4) A sworn statement from the physician and the hospital itemizing the service rendered and the charges therefor . . .

* * *

"(5) A letter from the employing department, stating its recommendations upon . . . (b) the necessity for the medical, surgical and hospital treatment, (c) the reasonableness of the bills incurred for such treatment and for medicines; . . ."

Physicians should submit their reports promptly to the Commission. Delay may mean the withholding of compensation to the injured employe and of professional fees to the physician.

Physicians must keep in mind the fact that where an appearance as an expert witness is made for a claimant and no award is granted, they must look directly to the employe for payment. Furthermore, where a physician treats an injured employe and such treatment has not been authorized by the employer, and the Industrial Commission finds no liability on the part of the employer, the physician must look directly to his patient for payment.

Estimating of Permanent Disability Under the Wisconsin Workmen's Compensation Act

With a general broadening of panels of physicians for the purpose of treating injured employes under the Wisconsin workmen's compensation act, it becomes desirable for physicians to have a clear understanding of the estimating of permanent disability under terms of the act. A study of the act as to benefit provisions, and particularly of the provisions of Sections 102.42, 102.43, 102.44, 102.52, 102.54, 102.55, 102.555, and 102.565, is recommended. Copies of the compensation act in pamphlet form are available and will be forwarded by the Industrial Commission to any interested physician upon request.

Under the provisions of the workmen's compensation act, injuries may be divided into two types for the purpose of estimation of permanent disability, i. e., nonschedule and schedule injuries.

Nonschedule injuries. Nonschedule injuries are those to some portion of the body other than the legs, arms, ears or eyes, or their constituent parts.

Generally speaking, nonschedule injuries are to the torso or to the head, exclusive of eye and ear injuries.

In the case of nonschedule injuries permanent disability is based upon wage loss consisting of such percentage of the average weekly earnings of the injured employe computed according to the provisions of the compensation act "as shall fairly represent the proportionate extent of the impairment of the injured's earning capacity in the employment in which he was working at the time of the injury, and other suitable employments, the same to be fixed as of the time of the injury, but to be determined in view of the nature and extent of the injury." (Sec. 102.11(3) Stats.) If the disability is such as to render the employe unable to perform substantially all the material duties of his own occupation, or of any other remunerative occupation which his age, training, experience, education and physical condition would fit him for, except for his disabling infirmity, his disability is total. The Wisconsin Supreme Court has held that a man's wage earning capacity is to be distinguished from his capacity to make money in a business conducted under his supervision or direction, and with the use of investment of other capital than that which arises from his own labor. The question thus resolves itself into one of employability, using care to distinguish the nonemployability resulting from the employe's physical condition from that which results because of economic conditions or other circumstances which might limit employability regardless of the employe's physical condition. In the case of one who is fitted to perform labor only, a back injury of a certain severity may cause considerable wage loss, while in the case of one suited for clerical work the same physical disability, in terms of wage loss, would be much less serious. The limitation in capability to work within a limited field of employment must be considered in determining the percentage of impairment of earning capacity. With such double limitation the probability of wage being earned by the employe is obviously more largely curtailed, and probable wage loss is greater.

Schedule injuries. Schedule injuries are estimated upon a different basis, which bears no relation to wage loss. In these cases *the comparison is as between the injured limb and a normal limb,* having in mind all of the useful functions of the limb or organ. Schedule injuries apply to arms, legs, eyes and ears, as well as any constituent part of these members and organs. The estimate of disability takes no regard of any particular occupational use to which the member is to be put. The violin player who has lost a digit vital for the purpose of playing, and who may consequently lose much wage, receives exactly the same number of weeks' compensation as does the laborer who may be able to perform his work nearly as efficiently as before, even with the loss of a digit. The law fixes the value of each finger, thumb, toe, hand, arm, foot and leg at various joints. In the estimation of disability the doctor takes into consideration the percentage of loss of function which has resulted to the given unit as of the joint at which disability exists, or if disability is between joints, at the joint proximal to the point of disability. For example, if there is disability proximal to the wrist, but no disability above the elbow, the comparison is of the arm with a normal arm at the elbow, or, put conversely, with an arm which has been *amputated* at the elbow.

Because in every case of schedule injury, where there is a certain limitation of motion with no other element of disability involved, the functional disability is the same as in all identical cases, the estimate in such cases should be uniform. If the employe has lost his ability to raise his arm at the shoulder beyond the horizontal level and has no other disability, the estimate should manifestly be the same in his case as in all other cases where the limitation of motion is identical and where no other disability has resulted.

In case of schedule injuries the Commission has found it possible to establish by custom or rule the related disability applicable to a given handicap. After many hearings with physicians, and in cooperation with the State Medical Society, the Commission has adopted a schedule of related disabilities to serve as a guide in rating disabilities *short of amputations or total loss of all function.* In the example cited, where the loss of function is represented by a limitation of active elevation of the arm in all directions to 90 degrees, but otherwise normal, *the loss is interpreted at 20 per cent of the arm at the shoulder.* In all of the cases where landmarks have been adopted, the percentage of disability must vary as other conditions exist which constitute elements of functional loss. *If, for example, in addition to limitation of motion, there is disabling pain or weakness, a percentage must be added for these elements.* As the Commission has adopted landmarks only for loss of certain specified functions representing disability, the physician must exercise his best judgment as to the percentage to be added for other items which may conduce to disability.

As a guide for the estimating of disabilities the Commission has adopted the following table *representing per cent of loss of use as compared with amputations at involved joints.*

Shoulder

Total ankylosis at the shoulder with arm at side, scapula fixed	75%
Total ankylosis at the shoulder with arm at side, scapula free	55%
Limitation of active elevation to 45° but otherwise normal	35%
Limitation of active elevation in all directions to 90° but otherwise normal	20%
Limitation of active elevation to 135° but otherwise normal	5%

Elbow

Ankylosis of elbow joint at 45° less than full extension (radio-ulnar motion destroyed, hand 45° less than fully pronated)	60%
Limitation of motion of elbow joint (radio-ulnar motion unaffected)	
Remaining range, 90°–135°	20%
Remaining range, 135°–180°	35%
Ankylosis of radius and ulna, estimated at elbow joint (hand 45° less than fully pronated)	20%

Wrist

Ankylosis, straight position	25%

Fingers

Complete ankylosis Thumb	Mid-position	Complete Extension
Distal joint only	25%	35%
Proximal joint only	15%	20%
Distal and proximal joints	35%	65%
Distal, proximal and carpometacarpal joints	85%	100%
Fingers		
Distal joint only	25%	35%
Middle joint only	75%	85%
Proximal joint only	40%	50%
Distal and middle joints	85%	100%
Distal, middle and proximal joints	100%	100%

Loss of Motion Fingers	Loss of flexion	Loss of use	Loss of extension	Loss of use
Distal joint only	10% =	1%	10% =	2%
	20% =	2%	20% =	4%
	30% =	3%	30% =	6%
	40% =	5%	40% =	8%
	50% =	10%	50% =	15%
	60% =	15%	60% =	20%
	70% =	20%	70% =	30%
	80% =	25%	80% =	40%
			100% =	60%
Middle joint only	10% =	5%	10% =	2½%
	20% =	10%	20% =	5%
	30% =	15%	30% =	10%
	40% =	25%	40% =	15%
	50% =	40%	50% =	30%
	60% =	50%	60% =	50%
	70% =	60%	70% =	70%
	80% =	70%	80% =	90%
			100% =	100%
Proximal joint only	10% =	5%	10% =	2½%
	20% =	10%	20% =	5%
	30% =	15%	30% =	15%
	40% =	20%	40% =	20%
	50% =	25%	50% =	25%
	60% =	30%	60% =	40%
	70% =	35%	70% =	75%
	80% =	40%	80% =	85%
			90% =	100%

(Where there is partial disability to two or more phalanges the estimate of the physician should take into consideration the greater cumulative effect because of such multiple disabilities. By analogy the allowances for complete ankylosis, where two or more joints are affected, may be used as a guide for comparison as to the greater allowance to be made because of the combined disabilities to two or more phalanges.)

Hip

Ankylosis in alignment for normal standing position	50%
Shortening of leg (no posterior or lateral angulation, age 50 or less)	
1 inch	7%
1½ inches	14%
2 inches	22%

(The percentages compare loss of the leg at the hip.)

Knee

Ankylosis at 170°	40%
Limitation of motion, remaining range 135°–180°	20%

Ankle

Ankylosis at right angle	30%

Report form. For use in reporting disabilities under the compensation act the Commission has adopted a form for use of physicians.

In order to enable the Commission to pass upon disability it becomes necessary that the physician's report contain as a minimum all of the information requested by this form. If in any case use is not made of the form, the physician should make certain that the requirements of the form are met. That will save returning the form to the physician with request for supplementary report.

In addition to this form the Commission also makes use of a form for use in cases of loss of vision, which will be supplied to physicians upon their request, together with rules for determining loss of visual efficiency caused by industrial injury. In the case of partial deafness, no fixed rule has been adopted for determination. The physician should make use of recognized standards in reaching an estimate as to the percentage of loss of hearing which has resulted.

Estimates of Disability

Obviously methods of estimating must be in accordance with the law, regardless of the personal feeling of the physician as to the correctness or justice of the law. In general, parties are probably in agreement as to the essential justice of these provisions. However, physicians may at times have some doubt in individual cases as to the equity of one or other provision, or may feel that the law is harsh or inadequate from the standpoint of either employer or employe. That feeling should never be allowed to influence the physician, either in treating or in estimating disability.

The physician who estimates disability should, under no circumstances, concern himself with the result in number of weeks or in dollars but should confine himself strictly to the medical field in estimating the disability on a functional basis. It is clear that if the physician is influenced by the amount of compensation which may be paid to the

injured, his estimate will not be on a valid basis. Neither should physicians attempt to compute the amount of compensation to become due. The law fixes the amount to be paid on the basis of disability which has resulted. This amount may be much greater or smaller than one or another physician might consider to be equitable. Computation of compensation based on estimates of disability is a function for the Industrial Commission. Attempts of physicians to compute very often result in erroneous figures and thus cause confusion and misunderstanding, both on the part of the physician and the injured person.

In the estimating of disabilities to members included within the schedule group, it should be remembered that 50 per cent loss of motion, or 50 per cent loss of strength of itself *does not necessarily mean 50 per cent loss of function of the limb.* All functions of the limb must be considered, such as motion, freedom from pain, strength, coordination, quickness of action, endurance, sensation, etc. To each factor must be assigned by the physician the percentage which he considers represents the proportion of functional use of that factor as compared with all functions of a normal member, and to each factor must be applied the percentage of loss of the particular factor which has resulted. The total of the resulting percentages constitutes the percentage of disability to the member involved.

In those cases in which loss of motion is greater or less than that represented by the landmarks established by the Commission, the physician must add or subtract such percentage as he believes will fairly represent the greater or smaller percentage of disability found to have resulted. In making his estimate the physician will be guided by the landmark laid down for the most nearly comparable disability for which a landmark has been established.

The cooperation of physicians is earnestly solicited by the Commission in the making of prompt and complete reports to employers and insurance carriers, making it possible for them to pay compensation speedily and without interruption when due to employes. The Commission feels that those physicians who, because of press of other business, or because of a lack of desire on their part to participate in the compensation program, find it impossible to do justice to the parties, or to make all necessary reports promptly, should not be included in panels for the purpose of treatment of injured employes. Physicians have it within their power to hasten or delay the payment of compensation which is clearly due. Time is of the essence under the workmen's compensation act in the payment of compensation to those who usually are in urgent need because of their unexpected misfortune.

In this connection it should be pointed out that many reports have to be returned to physicians because of use of terminology which does not follow that set out in the statute. For example, the statute refers to the thumb, index, middle, ring and little fingers, and to disability at the distal, second and proximal joints. Some physicians refer to the first, second, third and fourth fingers, and some designate the thumb as the first finger. Also some physicians speak of the interphalangeal joints, and sometimes of the first, second and third joints, leaving confusion as to the point of measurement. If physicians will use the language of the statute, a good deal of confusion and necessity for supplementary reporting can be avoided.

As it is the Commission's ultimate function to fix the percentage of disability, full reports covering all factors should be made, setting out in detail the elements which constitute disability, and stating as nearly as possible the weight and percentage of loss which has been ascribed to each. The physician should also set out his opinion as to the ultimate total percentage of disability which has resulted. That enables the Commission to check the report with the Commission's standards and to arrive at an intelligent and uniform conclusion.

From time to time physicians propose certain standards or schedules for the measurement of disability. The Commission wishes to call attention to the fact that no standards or schedules not adopted by the Commission have the approval of the Commission. Only those standards adopted and published by the Commission itself should be considered as authoritative or as representing the Commission's thought as to percentages of disability based on certain functional losses. It is appreciated that other schedules may be studied as a matter of interest by physicians who will undoubtedly wish to arrive at an opinion based upon their own examination and analysis and by reference to the standards which the Commission has authoritatively adopted.

It has not been the purpose of this resume to conduct an exhaustive analysis of the law in the many ways in which it may be related to the physician and his patient. Many questions will doubtless remain in the physician's mind.

But if the panel physician will appreciate the technical detail of much of the law and its administrative characteristics, he will find it easier to deal with the employer, the insurance carrier, and the patient. Both the office of the State Medical Society and the Industrial Commission will be happy to be of assistance in the medicolegal problems confronting the physician who treats patients entitled to, or claiming, benefits under the act. Inquiries may be directed either to the State Medical Society or to Mr. Harry A. Nelson, Director of Workmen's Compensation, State Capitol Annex, Madison, Wisconsin.

Agreement on Panel Practice

At the suggestion of the insurance companies selling workmen's compensation insurance in Wisconsin, the State Medical Society of Wisconsin entered into a joint agreement with them to permit employes eligible to benefits under the workmen's compensa-

tion act to have free choice of physician. Through the medium of this agreement any member of the State Medical Society of Wisconsin who indicates his willingness to serve injured employes may have his name included in the panel which is certified to the insurance companies. This agreement makes it possible for from 75 to 80 per cent of the employes in Wisconsin to have a wide choice of physician.

The attention of members is specifically called to the provision under the application for placement on panels that the member agrees to have consultation when so requested by the insurance carrier. The member also agrees to communicate with the insurance carrier in regard to the consultant in order that the consultant might be mutually agreed upon. It is recognized that exceptions will occur to this portion of the agreement, but the exceptions should occur only in the event of an emergency.

The agreement on panel practice in Wisconsin as adopted by the Council of the Society and the insurance company associations is as follows:

Agreement on Panel Practice in Wisconsin

The workmen's compensation law of Wisconsin requires all employers to maintain a panel of five physicians, from which an injured employe shall have the right to make choice of an attending physician in case of accident. In many communities the common interests of the employer, the injured employe and of the medical profession will be more equitably served by liberalizing the minimum statutory requirement. In order to provide a larger medical panel from which the injured employe may select his attending physician, representatives of both the stock and mutual insurance companies writing compensation coverage in the State of Wisconsin, and representatives of the State Medical Society of Wisconsin, established the following principles:

1. The State Medical Society will prepare, and make available to insurance carriers, panels listing the names of all those physicians in each component county society desiring to accept employes eligible for treatment under the workmen's compensation act. This list and the panels will be kept as accurate as possible, but need not be revised more often than January 15 and July 15 of each year. If any panel distributed by an insurance carrier includes the names of any physicians not members of the State Medical Society, nothing thereon shall indicate that it has been approved by said Society.

2. A State Conference Committee of four, two representing insurance carriers and two representing the State Medical Society will be established, whose function it will be to coordinate the obligations of the insurance carriers with the facilities of the medical profession to provide proper benefits to injured employes. Specifically such committee shall have the duties of:

a. Mediating, if possible, those cases where the insurance companies complain that the attending physician has neglected or refused to furnish the reports reasonably necessary.

b. Mediating, if possible, those cases where it is complained that the insurance carriers have unreasonably interfered with what is properly in the discretion or control of the attending physician.

c. Reviewing any situation in which it is claimed that there has been a violation of medical ethics and, in its judgment, referring any facts relative thereto to the Board of Censors of the County Medical Society.

d. Mediating, if possible, differences that may arise between the attending physician and the insurance carrier relative to remuneration.

e. Hearing any complaints relative to the competency of those serving on such panels and removing their names therefrom if, upon investigation, it is found that such complaints are justified.

In the event of complaints from either insurance carriers or physicians the State Conference Committee may designate a special local committee to investigate and report to the State Conference Committee with recommendations as to the action to be taken. Both the State Conference Committee and the special local committees will attempt to mediate only those cases wherein the physician involved is on the listing provided by the State Medical Society.

3. It is understood that this is a trial plan and is necessarily limited to the State of Wisconsin. Any modifications of this general statement of principles to be effective must be approved by the State Conference Committee.

First—Aid Care

The question of first-aid facilities is one of increasing importance particularly in concerns employing a substantial number. First aid should be rendered by the physician whenever possible, and where this is not possible a physician should be obtained without delay so that first-aid measures may be conducted under his supervision. This subject was covered in a bulletin republished by the State Medical Society of Wisconsin in 1941 under the title "Suggestions for the Guidance of the Nurse in Industry."

RESTRICTION OF DISTRIBUTION OF DRUG SAMPLES

Since 1901 the Wisconsin statutes have made it a misdemeanor for any person by himself, or through an agent, or as the agent of another to leave, throw, deposit, or have in his possession with intent to leave, throw or deposit upon a doorstep or premises of another, or to deliver to any child under the age of fifteen when unaccompanied by an adult, any patent or proprietary medicine, preparation, pill, tablet, or drug containing poison or other ingredients deleterious to health, as a sample or in any quantity whatever for advertising or other purposes. The misdemeanor is punishable by a fine of $25 to $100.

The physician can perform a public health service in reporting to health or police officials any local violation of this law contained in section 97.70, statutes.

Privileged Status of Testimony of Physicians and Surgeons in Legal Proceedings

THE present law relating to privilege accorded the testimony of physicians and surgeons in Wisconsin courts is as follows:

325.21 **Communications to doctors.** No physician or surgeon shall be permitted to disclose any information he may have acquired in attending any patient in a professional character, necessary to enable him professionally to serve such patient, except only (1) in trials for homicide, . . . (2) in all lunacy inquiries, (3) in actions, civil or criminal, against the physician for malpractice, (4) with the express consent of the patient, or in case of his death or disability, of his personal representative or other person authorized to sue for personal injury or of the beneficiary of an insurance policy on his life, health, or physical condition.

This statute refers only to the testimony of a physician or surgeon in legal proceedings, and is to be distinguished from subsection (d) of section 147.20 (1), Wis. Stats., which provides for revocation of the license of a physician or surgeon for wilfully betraying a professional secret. Testimony within the protection of the statute includes information given by the patient in good faith, even when the physician or surgeon could have diagnosed and prescribed without it, and may include the physical circumstances of an injury and its occurrence, or the previous condition of an injured part of the body if, in the opinion of the physician or surgeon, such information is necessary to enable him to serve the patient.

The law relating to privilege is statutory and has no basis in the common law. Accordingly, the tendency of the court is to interpret the statute strictly and literally and to enforce only such restrictions as the statute specifically imposes, and not to add restrictions which the legislature may have omitted. As a result, certain interpretations and constructions of the statute have been made which are important to know.

For a long time the Wisconsin Supreme Court has adhered to the doctrine that a physician or surgeon may testify, or may be compelled to testify, to a condition observed by him when unconnected with treatment, even when the person observed or examined for purposes other than treatment is or was a patient of the physician. Following this principle the court has held that a physician or surgeon may testify as to a death certificate made by him, or as to an autopsy performed by him. Similarly, the Attorney General has held that the information acquired by a local health officer is not privileged when he examines a person in the course of his statutory duties as such officer.

In a recent decision the court has held that a nurse could testify, although the doctor could not, as to a record made by her at a patient's admission and during his treatment, in spite of the fact that the record was used by the doctor in treating the patient, because the statute specifically names only physicians and surgeons. For this same reason, testimony of an interne attendent or roentgen ray operator, or the roentgenogram made by him, is not privileged.

The privilege of the statute may be waived by the patient himself, or by his personal representatives or by beneficiaries of an insurance policy. Although it might appear from a reading of the statute that waiver by a personal representative is to be permitted only in personal injury cases, nevertheless, the court has very recently held that the personal representative may waive the privilege and introduce the testimony of a decedent's physician as to the health and physical condition of the decedent prior to death in a case involving a tax on gifts made in contemplation of death.

Exceptions from the privilege, of course, are those facts learned by the physician in observation or treatment of a person or patient which he is by statute required to report to the proper authorities. Among these are communicable diseases, including venereal disease; cancer, carcinoma, sarcoma or other malignant growths; and occupational diseases. See the article on this subject on page 127.

Among the more common situations arising today in which the physician is asked to disclose privileged information are those in the preemployment or periodic health examination of employes, and those in which an insurance company seeks information to serve as a basis for writing a policy in favor of the patient or for adjusting a claim made by a patient who may carry health, accident or sickness care coverage. For his own protection, the physician must always obtain the signed authorization of the patient before divulging such privileged communications. Such authorization should also identify the person or organization to which such disclosure may be made, and should specify the information to be disclosed. The physician should not disclose information beyond that permitted by the authorization, for if he should go beyond the limits of the patient's waiver, he may be charged with wilful betrayal of a professional secret. Insofar as the periodic health examination or preemployment examination of employes in industry is concerned, the State Society has perfected a specific form of release which appears on model examination forms, approved by the Industrial Commission. These forms are available through the State Medical Society at the cost of printing.

While it is difficult to express a general principle, a physician who is rendering a bill to poor relief

authorities for professional services rendered relief patients should avoid reporting details beyond those absolutely necessary for reimbursement.

Upon making a premarital examination the physician may find that while the applicant is free from venereal disease, he does have some physical or mental disability or abnormality which would render him unfit for marriage or would make impossible the consummation of a satisfactory marriage relationship. The question then arises as to the liability of the physician upon disclosure of his findings to the other prospective spouse.

This problem is discussed in an article appearing in *The Ohio State Medical Journal* for November, 1941. Believing that the conclusions there drawn are of equal merit in Wisconsin we reprint here the conclusions both as to (1) the liability of the physician to the examiner, and (2) the liability of the physician to the state.

"A physician, disclosing to the other prospective marital partner disabilities or ailments of an examinee that would endanger the other party to the prospective marriage or that it would make it impossible for the parties to enjoy a happy or satisfactory marriage relationship, is subject to no liability to the examinee, either in libel or slander or for disclosing a professional secret within the limitations noted; that is, if he acts in good faith and without malice and makes no further disclosures than is reasonably necessary under the circumstances. Obviously, the problem is simplified if the same physician examines both parties with the definite understanding that findings and observations, if at all material to the prospective relationship, shall be made known to the other party; or if the physician acting with respect to one party only enters into a similar understanding."

"The disclosures under the circumstances here assumed would not constitute the 'wilful betrayal of a professional secret' and would not be the basis for the revocation of the physician's license."

In addition to the privilege statute itself, there has been since July 1, 1939, a rule promulgated by the Supreme Court which has the force of statute and reads as follows:

The court or a presiding judge thereof may, upon due notice and cause shown, in any action brought to recover for personal injuries, order the person claiming damages for such injuries to submit to a physical examination by such physician or physicians as such court or a presiding judge may order and upon such terms as may be just; and may also order such party to give to the other party or any physician named in the order, within a specified time, an inspection of such X-ray photographs as have been taken in the course of the treatment of such party for the injuries for which damages are claimed, and inspection of hospital records and other written evidence concerning the injuries claimed and the treatment thereof; and if compliance with the portion of said order directing inspection be refused, the court may exclude any of said photographs, papers and writings so refused inspection from being produced upon the trial or from being used in evidence by reference or otherwise on behalf of the party so refusing. Sec. 269.57 (2).

This rule is restricted to personal injury cases. That part which deals with a physical examination of the injured party is not inconsistent with the privilege statute because the examination is being made not for treatment but for a purpose independent thereof. As to its effect on introduction of records in a trial, it will be noticed that the order does not compel a party to permit inspection of such records and written evidence, but provides a penalty in case of refusal in that the party refusing may not himself use them or produce them in the trial.

PROFESSIONAL DISCOUNTS

Many physicians have at some time entered into contracts with pharmaceutical supply houses under which a professional discount was allowed. These contracts may be drawn initially to extend for a year from the date of execution. However, it frequently occurs that after the term of the original contract has run, the physician continues to make purchases with the expectation that the discount will be continued. This expectation is not always realized and the result is a dispute between the supply house and the physician.

Because honor and integrity alone will not prevent dispute or dissipate it, it is well to remember that contracts, other than those of lease, do not automatically renew themselves so as to incorporate all terms of the original agreement unless specific provision therefor is made. Thus there is no reason why the supply house legally could not refuse the discount as to purchases made after the expiration of the original contract, whatever the physician many have assumed as to renewal.

Many supply houses undoubtedly extend discounts beyond the original term as an expression of good will. Because some of them do not, however, it is wise to **examine your contract critically noting the date of expiration. Confirm in writing your understanding as to renewal and for what period of time.**

Coroners and Autopsies

A COMPLETE discussion of the powers and duties of the coroner would necessitate covering as well the powers and duties of the sheriff or constable, for in the event that a sheriff or his deputy, for one of several reasons, is prevented from performing the duties of that office, the responsibility becomes that of the coroner. Since only in rare instances does such a situation arise, and since such powers and duties bear little or no relation to matters pertaining to physicians, this discussion is limited to the more familiar and specific powers and duties prescribed by law.

The principal contact of the practicing physician with a coroner is in connection with the performance of autopsies requested by that officer. It should be emphasized that unless the physician has the express consent of the immediate family of a decedent, he subjects himself to the possibility of a lawsuit and the payment of damages by performing an autopsy excepting where directed to do so by a:

1. Subpoena issued by a coroner or his deputy subsequent to the ordering of an inquest.
2. Subpoena issued by a justice of the peace who has been ordered by the district attorney to conduct an inquest in the absence of a coroner.

Ordinarily a coroner, his deputy, or an authorized justice of the peace first contacts a physician to inquire whether he is available to perform an autopsy. The physician thus has notice of the intended autopsy before being served with a subpoena. The prudent course for the physician, unless he has personal knowledge of the steps taken and the summoning of an inquest jury, is to make sufficient preliminary inquiries to satisfy himself that such inquest has been ordered. Where the subpoena comes from a justice of the peace he should also check with the district attorney to make sure that the district attorney requested the justice to act in the capacity of the coroner because of the latter's absence. Only by observing such precaution will the physician protect himself against suit by the family of the decedent. See *Koerber v. Patek*, 123 Wis. 453. For fuller treatment of this liability see article on "Malpractice and Malpractice Suits," on page 82 of this issue. Where the situation contains any element of uncertainty, the physician would do well for his own protection to consult his own attorney.

Section 59.34, of the Wisconsin Statutes, provides in part that the coroner shall take inquest of the dead when required by law, and shall perform all other duties required by law.

The most important duty, of course, is that relating to inquests, the details of which are set forth in chapter 366 of the Wisconsin Statutes. The legislature has deemed it advisable to leave with the coroner a wide range of discretion.

Section 366.01 provides that when, from the circumstances surrounding the death of any person, the district attorney shall have good reason to believe that murder or manslaughter has been committed, he shall order and require the coroner or his deputy to take "an inquest on the view of the dead body of such person." The statute, however, also gives the coroner, on his own initiative, the power to hold an inquest. The function remains substantially as it has for several centuries. The inquest must be held in the county where the wrongful act or accident occurred regardless of the fact that the resulting death took place in another county.

The coroner's source of information of the death of a person is, of course, varied. Everyone, including a practitioner, owes a duty to report a death to proper authorities when circumstances indicate that a homicide or manslaughter may be involved. A physician, presumably, would be in a better position to draw such conclusions than would a layman; and where the practitioner attends a death involving suspicious circumstances, he would do well to notify the coroner or the sheriff's office.

Inquests

The coroner's first duty, upon being notified of a death, in absence of any request by the District Attorney to hold an inquest, is to determine whether or not in his opinion the facts warrant or require the holding of an inquest. This duty is purely discretionary; the only limitation, presumably, being that which relates to the District Attorney, that is whether there is good reason to believe that murder or manslaughter has been committed. It is impossible to lay down any rules for use in determining when good reason exists. Whether or not the coroner acts will, of course, depend on a number of facts: the objective circumstances of the case, incidental information available to the coroner, and, not to be overlooked, the coroner's own conception of the duties of his office.

Having concluded that the circumstances warrant or demand the taking of an inquest, the coroner's next step is to issue a so-called precept or order to the sheriff or constable to "summon a jury of six good and lawful men of the county to appear before him at the time and place specified in the precept." (In this connection it is pointed out that the power to hold an inquest is an absolute one and should the body have been buried, the coroner or his deputy can compel such body to be exhumed for the purpose of complying with the provisions of chapter 366, provided an inquest has been ordered.) The form of the order compelling the summoning of a jury is prescribed by the statutes. No time limitation is provided for setting the date of the inquest, but the desirability of prompt action in in-

quests is self evident, and it is the coroner's duty to see to it that prompt administration of the laws be accomplished. In addition to the order compelling the attendance of the jurors, the coroner may issue subpoenas of witnesses, included among which might be one or more competent physicians or surgeons, for the purpose of making an examination of the body and testifying as to the result of the same. Thus, in the exercise of his powers and duties the coroner is called upon to perform functions which are in their nature both judicial and medical.

Medical Functions

The most important medical duty is the investigation of deaths in which an element of violence may be suspected. These might include accidental or suicidal deaths, and deaths of persons who have not been attended by a duly licensed practitioner of medicine, when the cause of death appears uncertain. In making an investigation, the first consideration is how far it will be necessary to carry the examination, a matter which requires the exercise of care and good judgment. The coroner's questioning should be careful and searching, but having satisfied himself as to the natural cause of death, he is justified in going no further in his investigation. If, however, the death requires the discovery of facts other than those which may be revealed by questioning and inspection the coroner must be in a position to avail himself of those highly specialized medical services involved in an autopsy.

Quasi—Judicial and Other Duties

Having decided on the necessity for an inquest, the coroner's duty immediately becomes one of both an administrative and a judicial character. In Wisconsin, properly speaking, he is not a judicial officer under the state constitution. 20 Atty. Gen. 323. Nevertheless he has the power to exclude the public from inquests whenever he deems that to be desirable. He does the work of a practicing attorney in bringing out the testimony of witnesses, who are not, as a matter of right, entitled to representation by attorney. The statute provides that the jury is to find not only what caused the death, but who was responsible for it. Because of the informality of the procedure, the coroner is in a position to exercise a great influence over the jury even though the jury's findings are not admissible evidence in a subsequent court trial of an apprehended party. See Groeschner v. John Gund Brewing Co. (1921) 173 Wis. 366, at 370. Nevertheless the coroner can frequently be the primary force in bringing a criminal to justice.

Being in charge of the inquest, the coroner, of course, is not in a position either to perform an autopsy or to testify as to the cause of death. If he is a physician, however, his medical training would aid him substantially in preparing questions to be asked of the medical witnesses called. 1910 Atty. Gen. 578.

In the absence of the holding of an inquest the coroner is in no different position than an individual as far as stating the cause of death is concerned. Section 69.39 of the Wisconsin Statutes, provides, however:

> 69.39 Coroner's certificate. Any coroner whose duty it is to hold an inquest on the body of any deceased person, and to make the certificate of death required for a burial permit, shall state in his certificate the nature of the disease, or the manner of death, and if from external causes or violence whether "probably" accidental, suicidal or homicidal, as determined by the inquest; and shall, in either case, furnish such information as may be required by the state registrar to classify the death.

A further duty is imposed upon the coroner by Section 366.19, Wisconsin Statutes, which provides in subsection (2):

> It shall be the duty of the respective coroners of this state, in any case where the body is to be cremated, to view and make a careful personal inquiry into the cause and manner of death, and conduct an autopsy or order the conducting of an autopsy, if in their opinion it is necessary to determine the cause and manner of death, and thereupon certify that no further examination or judicial inquiry concerning the same is necessary, if so satisfied, otherwise, or in the event of doubt to proceed as otherwise provided by law.

This article does not even purport to treat the situation in which the physician performs an autopsy at the request or with the consent of the decedent's immediate family. In such cases no other authorization is required from the coroner or any other public officer. See "Malpractice and Malpractice Suits," page 82.

PHYSICIANS' EXEMPTION FROM JURY DUTY

Section 255.02 (2), statutes, provides in part for the exemption of all practicing physicians and surgeons from service as jurors. This exemption from jury duty is not a disqualification to act as a juror, but is a mere personal privilege which the juror may claim or waive.

Physicians desiring to take advantage of their exemption should appear in court if by oversight called for jury duty, and should state the fact of their profession to the presiding judge.

Narcotic Laws

General Statutes and Regulations

THE December, 1941, Blue Book issue of *The Wisconsin Medical Journal* contained an article written by the U. S. Commissioner of Narcotics, H. J. Anslinger, entitled "The Harrison Narcotic Act, and the Practitioner." This study which is not reprinted here is both authoritative and complete and sets forth in detail the provisions of the act and its relation to the practitioner. The Harrison Narcotic Act was technically drafted as a revenue measure, for only through the taxing power can the federal government control or regulate traffic in drugs within the states themselves, but it was primarily intended, as Justice Holmes pointed out in United States v. Jin Fuey Moy, (1916) 241 U. S. 394, to control and regulate the sale and use of narcotics.

The State Law

The federal act, however, because of constitutional limitations on the scope of its operations, was not sufficient. Supplemental state legislation was essential. This need was recognized by the proposal in 1932, by the National Conference of Commissioners on Uniform State Laws, of a "Uniform Narcotic Drugs Act," and since that time, forty-one states, including Wisconsin, have adopted the act; the Wisconsin Law being enacted by chapter 306, in the Laws of 1935 as chapter 161, Wis. Stats. The 1941 Legislature enacted several amendments which are noted below at appropriate places, and which are designed either to make the state act conform with the federal, or to strengthen administration of the act.

The state act was intended to facilitate the regulation, control, and enforcement, with particular emphasis on enforcement, of the use of narcotics in conformity with the aims and purposes of the federal act. In drafting the state law, effort was made to avoid any duplicate effort, either on the part of the enforcement officers or the persons subjected to the act. The state law makes specific reference to the federal act and provides that a compliance with the federal law shall constitute a compliance with corresponding sections of the state law. The procedure to be followed by practitioners and others subject to the law is adequately set forth in the article by Commissioner Anslinger, which was printed in the December, 1941, issue on page 1240. From it the practitioner may obtain the general procedure required of him. Some statutory requirements and penalties relating to the physician's professional use of narcotics and marijuana are summarized for the physician's convenience at the end of this article. There are certain additional factors which merit consideration by the practitioner, some of which arose subsequent to the passage of the Wisconsin law, and which, while not specifically falling under the provisions of the federal Harrison Narcotic Act, are related to the subject in a general way.

Use of Narcotics and the Practitioner

It must be remembered, first of all, that the practitioner can use narcotics only in connection with patients upon whom he is in attendance in the regular course of his professional practice. Except for the provisions of Sec. 161.27, Wisconsin Stats., forbidding the possession and use of opium pipes and Sec. 161.275, as enacted by chapter 49 of the Laws of 1939, outlawing smoking preparations of hemp or loco weed and the use of marijuana in a form suitable for smoking or beverage purposes, neither the state nor federal act places any limitation upon the quantity that may be used, the time during which it may be continued, or the form in which it may be administered.

The courts have, however, definitely held that the administering, dispensing and prescribing of drugs for the sole purpose of satisfying the craving of an addict is not within the limits of professional practice as contemplated by the act. In the use of such drugs the practitioner must always act in good faith. Because of this construction of the act by the courts and the similar position taken by the federal authorities the practitioner should take care to avoid any suspicion of noncompliance, not so much because of possible conviction but because of the trouble, expense and adverse publicity which might result should an innocent practitioner be charged with violation of the act.

Hitherto, certain small quantities of narcotics were exempt from the provisions of the state act where prescribed, dispensed, or sold at retail. A 1941 amendment limits the exemption to preparations which do not contain an excess of 1 grain of codeine or any of its salts in one fluid or avoirdupois ounce. The preparation containing codeine must also have medical value other than that possessed by the narcotic alone. All other preparations are now in the prescription class. In consideration of the narcotic law's application, the practitioner should keep in mind the following three phases of the problem: administration, dispensation, and prescription.

1. *Narcotics Administered by Practitioners.*—It is in this branch of the use of narcotics that the practitioner is given the greatest freedom. Under the federal law, he is not compelled to keep a record of the drugs administered either by himself or by his duly authorized assistant, intern or nurse. The state law, however, does require practitioners to

maintain a record of any narcotic drugs administered except—

Narcotic drugs administered, dispensed or professionally used in the treatment of any one patient, where the amount administered, dispensed or professionally used for that purpose does not exceed in any forty-eight consecutive hours, (a) four grains of opium, or (b) one-half of a grain of morphine or of any of its salts, or (c) two grains of codeine, or of any of its salts, or (d) one-fourth of a grain of heroin or of any of its salts, or (e) a quantity of any other narcotic drug or any combination of narcotic drugs that does not exceed in pharmacologic potency any one of the drugs named above in the quantity stated.

2. *Narcotics Dispensed by Practitioner.*—Under both acts, the practitioner is required to keep a record of all narcotic drugs dispensed by him, such record showing the amount, date dispensed, name and address of the patient; this record must be kept for two years. One record will suffice for both federal and state requirements. When the practitioner's office is accessible to the patient, the dispensing of narcotics should be avoided as much as possible; certainly no more should be placed in the hands of patients than is necessary to provide until the next visit.

Attention is called to a special rule applicable to physicians dispensing exempt narcotic preparations, such as paregoric. The rule is expressed both in the federal act and in the treasury regulations and provides that a dispensing physician, among others, must keep a record of all sales, exchanges, gifts or other disposition of such exempt preparations. The record of disposition must be made at time of delivery and must show the name and address of the patient, the name and quantity of the preparation and date of delivery. A 1942 amendment to the regulations holds this rule to be an independent requirement of law, binding on all physicians and others who dispense exempt preparations. Any violation of the rule is subject to the criminal provisions of the Harrison Narcotic Act.

3. *Prescribing by Practitioner.*—The laws do not compel the practitioner to keep records of the prescriptions issued, but the physician's case records should be complete and in detail. The practitioner should bear in mind that the best professional opinion seems to recognize the fact that an attempt to cure an addict outside the walls of a hospital or other institution is almost certainly doomed to failure, and that an attempt to cure under such circumstances may furnish grounds for suspicion of violation. Both the federal and state laws contain specific reference to drug addicts, and it is only in exceptional cases, such as those of aged and infirm persons, that a practitioner is justified in furnishing an addict with the means of obtaining a supply of drugs, and then only in the course of the physician's "professional practice."

The physician must never prescribe, dispense or administer narcotics to a "transient addict" merely to satisfy such addict's narcotic requirements. If the physician determines *after* a physical examination that the addict is in need of medical treatment and that as a part of such treatment he should have narcotics in an amount which is reasonable for the particular patient, the prescription, dispensing or administration of narcotics under such circumstances is within the law.

Marijuana

It should be noted that the Harrison Narcotic Act does not regulate the production, manufacture, sale or use of marijuana. Instead, this is made the subject of separate federal regulatory legislation which is in terms almost identical with that on narcotics. A physician desiring to administer, dispense, prescribe or give away marijuana must, in order to comply with the federal act, first be registered for such purpose separately from his narcotics registration and must keep records similar to but independent of those showing disposition made of narcotics. The Wisconsin act includes cannabis, of which marijuana is a variety, in the definition of narcotic drugs, thereby making the act uniformly applicable to coca leaves, opium and marijuana.

The definition of "cannabis" was broadened by a 1941 amendment so that the state act is now identical in that respect with the Federal Marijuana Act of 1937. The term "cannabis" under the statute now includes all parts of the plant Cannabis sativa L., whether growing or not, the seeds thereof, the resin extracted from any part of the plant, and every compound, manufacture, salt, derivative, mixture or preparation of such plant, its seeds, or resin. There is exempted from the definition only the matured stalks of the plant, the devitalized seed and seed products.

It should be noted that a 1941 amendment now requires that records be kept by the physician of *all cannabis dispensed*, as is already the federal law.

State and Federal Penalties

Violation of the statutes relating to narcotics or marijuana is made a crime, and the severe penalties imposed reflect a public policy which demands that the use of these drugs be limited to legitimate medicinal purposes. For violation of the federal narcotic act the statute provides penalties varying from a fine up to $2,000 and imprisonment up to five years, or both, to a fine up to $10,000 and imprisonment up to twenty years, or both, and for the imposition of more than one fine, or imprisonment, or both, for a given violation. The state penalties are not so heavy, being limited on the first offense to a maximum fine of $200, or a maximum jail sentence of three months, or both, and for any subsequent offense to a fine of $100 to $1,000, or imprisonment in the state prison up to five years, or both. The state statutes also provide that there shall be no prose-

cution under the state narcotic law where a person has been acquitted or convicted under the federal law for the same act or omission.

The penalty for violation of the federal marijuana law is a fine of $2,000 or imprisonment, up to five years, or both, and for violation of the general marijuana provisions of the state law, the same penalties as those set out above for violation of the narcotics provisions.

Patient "Narcotic Permits"

Neither the state nor federal laws confer on *any* narcotic or other governmental enforcing agent *any* authority to grant any kind of permit to any individual purporting to entitle him to have narcotics dispensed or prescribed for his personal use. The government, both state and federal, leaves this entirely up to the professional judgment and good faith of the medical profession. No such purported "permit" presented by a patient, has any legal validity whatever, and, therefore, affords the physician no protection.

Death of Registered Physician

Notice of the death of a physician registered under the federal Narcotics or Marijuana Acts should be given promptly to the Collector of Internal Revenue, Federal Building, Milwaukee, by his family, administrator or executor. The collector will forward instructions as to disposition to be made of narcotics or marijuana on hand. If the family, administrator, or executor of the deceased physician's estate so desires, authority can be obtained from the Collector of Internal Revenue to sell the stock of narcotics left by the physician. Such stock can be sold, for example, to another physician who is registered under the Narcotics or Marijuana Acts. It must be noted, however, that narcotics can be sold only to a physician registered under the Narcotics Act and that marijuana can be sold only to a physician registered under the Marijuana Act. If the family, or the personal representative, of the deceased physician prefers not to dispose of the stock by sale to another registered physician, unbroken packages can be returned to the original source of purchase, but broken packages of narcotics must be forwarded by prepaid express to the narcotics district supervisor, who at present is Mr. J. J. Biggins, 817 New Post Office Building, Chicago, Illinois.

Military Service of Registered Physician

In the case of a physician who enters military service and closes his office during such period, it is proper for him to retain his stock of narcotics and marijuana so long as he is careful to place it in a safe or some other place which will put it out of ordinary reach.

A medical officer in the armed forces who is authorized by the surgeon general of the Army or Navy to obtain necessary drugs and preparations for official use in the service is exempt from federal requirements of annual registration and the payment of the annual tax. A physician entering the armed forces who is certain that he will engage in no private practice requiring the use of narcotics while in service may advise the Collector of Internal Revenue at Milwaukee of this fact, and relinquish his narcotic registration number, dispose of his stock of narcotics as directed or permitted and cease to register or pay the annual tax until his return to civilian practice. However, a military, naval or contract physician who engages in any private practice which calls for the use of narcotics must retain his registration number, renew it annually, and pay the annual tax.

If the physician going into service has employed another physician to take over his practice, it will be necessary for such a substitute physician himself to be registered before he can use any of the stock on hand. One purchasing the practice of a physician going into military service must likewise be registered in order to purchase or use his narcotic or marijuana stock. The regular order form prescribed by the government must be used for this purpose.

Important Federal Requirements and Date Lines

1. A physician desirous of using narcotics or marijuana in the course of his professional practice, who is registering for the first time, may do so at any time of the year. He should first request a narcotics application form from the office of the Collector of Internal Revenue, Federal Building, Milwaukee. This should be carefully filled out, witnessed or notarized, and returned to the collector, together with a special annual tax of $1.

2. Physicians who have registered before under the narcotics law will receive reregistration Form 678 from the Collector of Internal Revenue in May of each year. This should be carefully prepared and returned along with the annual tax of $1 *on or before July 1 of each year.* A physician who does not receive a reregistration form on or before July 1 is under duty to request one from the collector.

3. There must accompany the registration application and annual tax a sworn inventory on Form 713 showing narcotic drugs on hand in the physician's office. This, like the reregistration and tax, must be filed on or before July 1 of each year.

4. A physician may *not* order narcotics on his own prescription blank, but must use the official duplicate order book prescribed by the Collector of Internal Revenue, which may be purchased from the Collector's office, Federal Building, Milwaukee, for 10 cents. The order book may be requested on Form 679.

5. Unless a physician has registered, paid his tax, and filed an inventory, on or before July 1 of each year, it is a violation of law for him to administer, dispense, prescribe, give away or transport nar-

cotics or marijuana until he has first complied with the law in all above respects. In the case of narcotics it is a violation of law for the physician even to be in possession of such drugs under these circumstances.

6. Fines are imposed on a physician who either negligently or wilfully fails to keep or display in a prominent place in his office the stamps denoting payment of the special annual tax on the use of narcotics or marijuana for professional purposes.

7. A physician who maintains two or more offices in different locations must register each office separately and pay the special annual tax of $1 for each.

8. The physician should report stolen narcotics at once to the narcotics district supervisor who at the present time is Mr. J. J. Biggins, 817 New Post Office Building, Chicago, Illinois. Accompanying the report should be an affidavit which sets out the circumstances of the theft so far as they are known to the physician, the quantity taken, and the further fact that prior to making the affidavit local police authorities have been notified of such theft. A copy of such affidavit is to be retained by the physician and filed with his other narcotic records so as to be available at any time for inspection.

9. The following should be reported promptly to the Collector of Internal Revenue, Federal Building, Milwaukee:

(a) Removal of office. This is merely a matter of reregistration and does not require a new permit or payment of an additional tax.

(b) Discontinuance. A registered physician desirous of discontinuing either his practice or the administration, prescription or dispensing of narcotics or marijuana should notify the collector of his intention not later than June 30, the close of the tax year. He will receive special instructions as to disposing of his stock, etc.

(c) Death. See "Death of Registered Physician," page 116.

10. The physician should remember that if he desires to use marijuana in the course of his professional practice he must register, pay a tax and furnish an inventory on marijuana independently of those same requirements for narcotics, the latter being restricted by statutory definition to opium or coca leaves, or any compound or derivative thereof.

11. No registration is required under the Wisconsin act by physicians desirous of making professional use of coca leaves, opium or cannabis.

12. Some physicians have recently purchased large stocks of narcotics, apparently for the twofold reason that they feared a shortage in available supply and a rise in prices. From information made available by the United States Commissioner of Narcotics, Hon. H. J. Anslinger, whose article was printed in the December, 1941, issue on page 1240, it appears that both premises are false, at least for the immediate future. The commissioner holds that a physician who purchases a stock of narcotics beyond his reasonable needs for the ensuing ninety days is making excessive purchases. The physician who has an excessive narcotic stock on hand runs the risk of theft, ties up his money, and also runs the risk of a special investigation by a narcotics agent.

The Wisconsin office for the Federal Bureau of Narcotics is located in the Federal Building, Madison, and any communications or inquiries should be sent to the narcotics agent at the above address.

IDENTIFICATION BY BLOOD TEST

Whenever relevant to the prosecution by the mother, or defense by the alleged father, in an illegitimacy action, the trial court may order the mother, child and alleged father to submit to one or more blood tests to determine whether the defendant can be excluded as the father of the child. The results of the test are admissible only to prove that the defendant is not the father; the results of a test which show only that the defendant might be the father are not admissible. Such tests are conducted by a physician or physicians, licensed to practice medicine and surgery, or by another duly qualified person or persons, not to exceed three, who are appointed by the court and paid by the county. Sec. 166.105, statutes.

Whenever relevant in a civil action to determine the parentage or identity of any child, person or corpse, the court may direct any person or persons involved to submit to one or more blood tests under restrictions and directions deemed proper by the court. Only where definite exclusion of the person involved in the controversy is established by the test are its results receivable in evidence. Sec. 325.23, statutes.

Sterilization

IN 1932, and again in 1938, opinions from the office of the attorney general of Wisconsin indicated the belief of that office that sterilization operations, except in the course of strictly therapeutic surgery, would be held illegal by the Wisconsin courts. Because of the importance of those opinions, they are printed here in summary.

1932 Opinion

The first of the two opinions was rendered by Deputy Attorney General Fred M. Wylie in 1932 in 21 Atty. Gen. 940:

"You ask opinion upon the following:

We have advised the county judge and the county children's welfare board that section 46.12 does not prohibit a sane person over twenty-one years of age from being sterilized, if he or she so wishes. We find no other section in the statute pertaining to sterilization. Please advise if our opinion was correct. Is a doctor protected in sterilizing persons who appear there voluntarily?

Is it possible for a county to pay for sterilizing indigents who are now receiving county aid and who voluntarily offer themselves for sterilization?

"Offhand, it is likely to appear that a competent adult may legally consent to be sterilized, not merely as a curative or preventive therapeutic, but solely to prevent procreation. I do not say that he or she may not, but there is sufficient contra indication in the law and in the disclosed attitude of some judges, to cause one to advise physicians that it is unwise for them to perform such an operation for sterilization purposes alone.

"Sterilization has not been received by the courts with any open-armed welcome. Against the opposition of those of the public and on the courts who consider such interference with nature to be immoral or sinful, legislatures have so far made no great strides, and a great deal of what has gotten past the opposition in legislatures has succumbed in courts.

"Even if we assume that the scientific and sociological view should prevail, nevertheless the law follows science, in some fields by perhaps a generation, for the law can reflect the advances of sciences only when they have been accepted by the people generally. Science may have a duty to educate the law, but it has no duty to defy it, nor to take a serious chance with it. The consequences to a physician from the performance of an operation of this kind, should the courts hold it illegal, could be serious. Until the law is settled, it is not prudent for a physician to perform a sterilizing operation except within the ancient field of surgery, viz., when it is a therapeutic measure.

"And if the poor relief officials should, as you suggest in your letter, become parties to the performance of such an operation, they, as well as the physician, would be liable to the penalties of the criminal law in case the courts should follow the letter of the old common law and hold that change in the application thereof can be only by legislative action.

"It is not my intention in this opinion to take any position upon the religious and sociological phase of the question. It is my personal and official opinion, however, that the legal question is better to be settled in the legislature than in the courts with some well-intentioned public official or physician as the potential victim."

1938 Opinion

The second of the two opinions was written by Assistant Attorney General Warren H. Resh in 1938, and is printed in 27 Atty. Gen. 416.

We quote the following excerpts:

"You ask whether a vasectomy 'can be performed safely' where the patient is willing to consent in writing and where it is the opinion of several examining physicians that the operation would benefit the patient's health. The man is not confined in an institution as a criminal, insane, feeble-minded or epileptic person and therefore sec. 46.12, Stats., relating to sterilization does not apply. No doubt you have in mind the mayhem statute, sec. 340.35, and the question is whether this statute would forbid sterilization in the present circumstances.

"The only case involving voluntary sterilization which has come to our attention is Christensen v. Thornby, (Minn.) 255 N. W. 620, a case notable in that the plaintiff sued on a theory of breach of warranty in that the operation did not have the desired effect, and he sought to measure his damages by the expense of a subsequent and unexpected childbirth. The court held that the contract was not void as against public policy, since it was thought to be necessary to save the life of the plaintiff's wife.

"In this regard necessity to save life and necessity to preserve health should stand on an equal footing, because of the difficulty of telling in some cases where one stops and the other begins. It is only because justified by the necessity to preserve health that a dentist who pulls an ailing incisor does not commit mayhem under the broad terms of the statute. Likewise with the physician.

"We conclude that vasectomy in the instant case may be excusable by reason of necessity to preserve health. For a more complete discussion of the subject we refer you to Miller and Dean's article in 16 Am. Bar Ass'n Journal 158 (1930). See also XXI Op. Atty. Gen. 940."

Tax and Permit Provisions of State Liquor Laws

UNDER the laws of Wisconsin, "intoxicating liquors" are defined as: ". . . all ardent, spirituous, distilled, or vinous liquors, liquids, or compounds, whether medicated, proprietary, patented, or not, and by whatever name called, containing one-half of one per cent or more of alcohol by volume, which are fit for use for beverage purposes . . ." Sec. 176.01.

Section 139.26 imposes a tax on intoxicating liquors but exempts those used by hospitals for medicinal or hospital purposes. Sec. 139.26 (1) and (1a). Section 176.401, Wisconsin Statutes, provides tax exemption for alcohol "intended for use and used in the manufacture and sale" of medicinal, pharmaceutical and antiseptic preparations when unfit for beverage purposes. There is no tax exemption for intoxicating liquors prescribed for medicinal purposes by a physician other than as those may be purely medicinal and not fit for beverage purposes. A substantial penalty is provided if patented, proprietary, medicinal, pharmaceutical, antiseptic, or toilet preparations are sold for intoxicating beverage purposes. Sec. 176.401 (2).

Those who deal in intoxicating liquors are generally required to secure a state license, but the physician (and hospital) is exempt from this requirement where his use thereof is "in the bona fide treatment of the sick or in using or prescribing such alcohol for such bona fide treatment." However, the physician must secure from the state treasurer a permit to receive shipments of alcohol for medicinal purposes. This permit will be issued without charge to any person who proves to the state treasurer that he uses such alcohol for medicinal purposes. Sec. 176.04 (3), also 176.404 (1), Wisconsin Statutes.

Because of the importance of the provisions in the laws relative to physicians and surgeons prescribing liquor in unnecessary amounts or under unnecessary circumstances the following provisions contained in Section 176.19 are printed here in full:

(1) It shall be unlawful for any physician or surgeon to prescribe intoxicating liquors for any person when unnecessary for the health of such person, or to prescribe a greater quantity of such liquor than proper for the ailment or disease of such person, with intent to evade or assist in evading any of the provisions of this chapter. Nothing in this chapter shall be construed as prohibiting any hospital or one licensed to practice medicine or surgery from having and using alcohol, in any form, in the bona fide treatment of the sick, nor as requiring either to have a permit or license to have, use, or prescribe the same for such bona fide treatment.

(2) Any physician or surgeon violating any of the provisions of this section shall be punished by a fine of not less than two hundred and fifty dollars nor more than one thousand dollars or by imprisonment in the county jail or house of correction not more than six months; and conviction for a second offense within any one year shall be ground for revocation of such defendant's license to practice medicine and surgery in this state.

Medical Aspects of Marriage Laws

THE Wisconsin statutes impose a number of conditions which must be fulfilled before a marriage can be recognized as valid in this state. Some of these are quite unrelated to medicine, but others have medical aspects. Only those which are peculiarly within the province of the practicing physician will be indicated below.

Premarital Examinations

1. *Freedom of male from venereal disease.*—The law requires all male applicants for a license to marry to obtain and file with the county clerk a certificate to the effect that the physician has thoroughly examined him and believes him to be free from any venereal disease, the examination to have been made within fifteen days of the marriage application.

The certificate provided by statute is in the following form:

I, _____ (name of physician), being a physician, legally licensed to practice in the state of _____, my credentials being filed in the office of _____ in the city of _____county of_____ State of _____, do certify that I have this _____day of _____19____ made a thorough examination of _____ (name of person), and believe him to be free from all venereal diseases.

_____(Signature of physician)

The physician must be one duly licensed to practice in Wisconsin or in the state where the male applicant resides. The fee for such examination and certificate, by statute, shall not exceed $2. Where the applicant is an indigent the examination is made without charge, on request, by the county or asylum physician. If, in the opinion of the examining physician, a microscopic examination for gonococci is required, it shall be made by the State Laboratory of Hygiene free of charge at the request of the examining physician.

2. *Negative Wassermann tests for both applicants.*—*Both* parties to a proposed marriage shall, within fifteen days of their application, be given a Wassermann or other standard blood test for syphilis. The test must be performed in a laboratory approved by the State Board of Health as competent to make such examination, or at the Wisconsin Psychiatric Institute free of charge, and if the results are negative a certificate in the following form is given the applicant:

I, _____(name of physician), being a physician, legally licensed to practice medicine and surgery in the state of _____ my credentials being filed in the office of _____ in the city of _____county of _____ state of _____ do certify that_____ (name of person) was given the Wassermann or other standard blood test for syphilis at _____ _____(name of laboratory) from blood taken by _____ on the _____ day of _____ 19____ and that the result of such test was negative.

_____
(Signature of physician making laboratory test)

Note: There is provision for nonresidents securing their blood tests in their own state requiring the submission of the original certificate from the laboratory together with a statement from the State Health Officer of the state (or his representative) to the effect that he believes the laboratory competent to make the test.

3. *Physician penalties.*—The statutes provide that any physician who knowingly and wilfully makes any false statement in either of the certificates set out above shall be punished by a fine up to $100 or by imprisonment up to six months.

4. *"Wassermann-fast" cases.*—Section 245.11 (4) provides:

In the case of an individual whose laboratory test for syphilis results in a positive finding, when in the opinion of his attending physician the individual no longer has syphilis in an infective or communicable stage, the state board of health may review the findings and clinical evidence through a deputy state health officer and thereafter the state health officer is empowered to grant a certificate to the county clerk that the individual is not in the infective or communicable stage of syphilis if such be his best judgment.

The effect of the above subsection is to make it possible for a syphilitic applicant to marry so long as his disease is not in an infective stage. Under a rule of the State Board of Health, made in September, 1939, a case of syphilis is ordinarily not considered "Wassermann-fast," or noncommunicable, until there have been at least twenty arsenical treatments and a similar number of treatments with heavy metals, all at proper intervals. Under this subsection, however, the rule is not applied arbitrarily but is relaxed as the merits of each individual case may warrant.

To avoid unnecessary correspondence, and in order to enable the examining physician to supply lacking information, forms have been prepared and are available from the offices of the State Board of Health on which physicians requesting special consideration of noncommunicable cases may make application to the state health officer. In accordance with provisions of the above section when this form is submitted by the physician, including his statement that in his opinion the individual no longer has syphilis in an infective or communicable stage, and if, after review of the files and clinical evidence by a deputy state health officer, it is the best judgment of the state health officer that the individual is not in an infective or communicable stage, he issues the required certificate which is sent directly to the county clerk.

The Attorney General of Wisconsin has recently ruled that only applicants who have submitted to a blood test for syphilis within fifteen days of applying for a marriage license, which test resulted positively, may avail themselves of the special procedure above provided. See 29 Atty. Gen. 354.

Marriage Laws

While the physician is not professionally concerned with the marriage laws of the state except insofar as he may be directed or authorized to make antenuptial physical examinations, nevertheless he is not infrequently asked for general advice in his position as family counselor. In Wisconsin, civil, not ecclesiastical, law governs the marriage contract. It is nevertheless complicated and to a considerable extent an unadjudicated field of contract law.

Under the Wisconsin law every male person who shall have attained the full age of 18 years and every female who shall have attained the age of 15 years is capable of contracting marriage if otherwise competent. Between the ages of 18–21 years as to the male and 15–18 years as to the female, consent of the parents or guardian, or an order of the county court of the county in which the marriage license application is pending, is necessary.

An attempted marriage on the part of one who is insane, imbecilic, feeble-minded, epileptic or idiotic is absolutely null and void in this state, cannot be ratified, and may be challenged by a party to the marriage or by one validly interested therein and either during or after the lives of either or both parties to the marriage. These are apparently the only marriages which are absolutely null and void from the beginning.

Where parties under age have failed to secure the consent of the parents, but have been married in good faith, their marriage is not void but merely voidable upon positive action by one of the parties or his guardian. Where the parties marry while under the lawful ages above set out, the marriage may be annulled unless the parties affirm the contract after reaching 15 years if it was the female who was not of proper age, or 18 years in the case of the male.

If a resident, who is disabled or prohibited by Wisconsin laws from marrying here, does so, such marriage is null and void for all purposes in this state. This has reference only to attempted marriage by the insane, imbecilic, feeble-minded, epileptic or idiotic, or those who have been divorced for less than one year. Other marriages, even though contracted in another state in order to avoid Wisconsin regulatory laws such as those relating to antenuptial physical examinations, are not invalid in Wisconsin. Where the ceremony is performed outside of Wisconsin and the parties return to it to reside, they are required under the provisions of section 69.48,

Wis. Stats., to fill out and file a blank marriage certificate with the local registrar of vital statistics within ten days after their return.

As previously indicated, the marriage laws of this state are complicated and cannot be applied by general rule to any given situation. The physician should have a general awareness of them in the sense that all matters concerning the public welfare and particularly the field of public health come within his professional concern.

Care of the Illegitimate Child*

WISCONSIN statutes relating to the care of the child born out of wedlock place the responsibility for the care, protection, and education of these children on the State Department of Public Welfare. Chapter 46.03 (11) (12) of the Wisconsin statutes provide:

46.03 General functions of the board.

(11) The board shall promote the enforcement of all laws for the protection of mentally defective, illegitimate, dependent, neglected and delinquent children, except laws whose administration is expressly vested in some other state department. To this end it shall co-operate with juvenile courts and all licensed child welfare agencies and institutions of a public or private character, and shall take the initiative in all matters involving the interests of such children where adequate provision therefor has not already been made or is not likely to be made.

(12) When notified of the birth or expected birth of an illegitimate child, the board shall, through advice and assistance of the mother, or, if necessary, independently of the mother, see to it that the interests of such child are safeguarded, that appropriate steps are taken to attempt to establish the paternity and that there is secured for him the nearest possible approximation to the care, support and education that he would be entitled to if born of lawful wedlock.

The Department of Public Welfare has delegated responsibility for this matter to its Division of Child Welfare. There is a limited field staff in this division, and the cases are therefore assigned to licensed child welfare agencies and children's workers depending upon the age, religion and legal settlement of the mother. The licensed agencies giving service in this type of case are:

The Children's Aid Society of Wisconsin
2835 W. Kilbourn Avenue
Milwaukee, Wisconsin

The Children's Service Association
734 North Jefferson Street
Milwaukee, Wisconsin

The Lutheran Welfare Society
3005 West Kilbourn Avenue
Milwaukee, Wisconsin

Lutheran Children's Friend Society
8138 Harwood Avenue
Wauwatosa, Wisconsin

Green Bay Diocese Apostolate (Catholic)
131 South Madison Street
Green Bay, Wisconsin

Catholic Welfare Bureau
3222 South Avenue
La Crosse, Wisconsin

Catholic Social Welfare Bureau
625 N. Milwaukee Street
Milwaukee, Wisconsin

Jewish Social Service Association
2218 North Third Street
Milwaukee, Wisconsin

Maternity Homes

If an unmarried, expectant mother requests the assistance of a physician in making confinement plans or plans for the child, it is advisable to communicate with the Division of Child Welfare, State Department of Public Welfare, Room 32S, State Capitol, Madison. Confinement care is often arranged at one of the several maternity homes in the state where only unmarried girls are admitted. These homes are:

Salvation Army Maternity Home
6306 Cedar Street
Wauwatosa, Wisconsin

Misericordia Hospital
2224 West Juneau Street
Milwaukee, Wisconsin

The Summit Hospital
Oconomowoc, Wisconsin

St. Ann's Hospital
1020 Market Street
La Crosse, Wisconsin

St. Mary's Mothers' and Infants' Home
403 Webster Avenue
Green Bay, Wisconsin

Admission to these hospitals may be arranged by writing directly to the superintendent of the hospital or to the Division of Child Welfare. All hospitals require a negative smear, Wassermann and throat culture before the patient is admitted. These hospitals admit Protestant or Catholic girls and the fee is $50 which includes care during confinement and

* Prepared for *The Journal* by Miss Dorothy Waite, Division of Child Welfare, State Department of Public Welfare, State Capitol, Madison.

three months after the birth of the child. The only exception to this is St. Ann's at La Crosse which admits only Catholic girls and charges a slightly higher fee. At these hospitals the girls are given some duties which contribute to cost of the care received. At Summit Hospital the girls may remain long enough to work out their entire bill.

Many girls do not want the group life which exists in maternity homes, and care in private family homes is often the best solution. Many private homes are willing to take a girl and keep her until confinement is needed, at which time the girl enters the hospital. This type of care is slightly higher in cost, averaging about $5 per week in the private home, and $50 to $60 for ten days' hospital care and the services of a physician. Any of the licensed agencies or the State Division of Child Welfare can give addresses of private homes where this kind of care can be arranged.

A three months' nursing period was at one time required, but after careful study by the agencies and the Division of Child Welfare regarding the relative value of breast feeding and artificial feeding, the Board of Public Welfare adopted the following policy in 1938:

Every child shall be required to be breast fed for a time to be determined by the attending physician unless it be not for the physical well being of the child or mother, or unless there exist other conditions which make such feeding impractical. In such exceptional cases properly supervised artificial feeding may be authorized.

This permits the agency to make separate plans for the child in a licensed foster home until the child can go to a permanent home.

Plans for the Child

Plans for the child in each case vary with the individual needs of the mother and child:

(1) If the mother wishes to keep her child with her and assistance from the father has not been possible, she is eligible for aid to dependent children through social security funds in the event that her own family is not able to give financial assistance.

(2) The child may be cared for in a temporary foster home pending the mother's decision to make permanent plans to keep the child either with herself or in an adoptive home.

(3) Adoptive placement may be made if the background and history of the child show that he is a suitable subject for adoption. The licensed agencies mentioned above are licensed to place children in adoptive homes. The advantage of this plan is that the mother and the adoptive parents do not know each other, and that the plan is worked out slowly and carefully so that the mother is not rushed into a decision of this kind and is less likely to change her mind.

(4) The mother may marry the father of her child. When this is done the birth may be legitimized, and the record is similar to that of any child born in wedlock.*

The laws regulating the placement of children place definite restrictions on any person or agency not licensed to perform this function. It is advisable for a physician immediately to refer any prospective adoptive couple or unmarried mother who wishes to release her child to the Division of Child Welfare or to one of the licensed child welfare agencies mentioned above in order to avoid violating the law.

The statutes read as follows:

48.37 **Licenses; records; reports.** (1) No person, other than the parent or legal guardian, and no firm, association or corporation and no private institution shall place, assist, or arrange for the placement of any child in the control and care of any person, with or without contract or agreement, or place such child for adoption, other than a licensed child welfare agency.

48.40 **Violations.** (1) Whenever the state board of control† shall be advised or shall have reason to believe that any person, firm, corporation, association or private institution, is conducting or acting as a child welfare agency in this state without being licensed as in this chapter provided, or is in any way, directly or indirectly, offering to place any child or holding himself or itself out as being able to place or dispose of children in any manner, it shall make an investigation to ascertain the facts. If it finds that such person, firm, corporation, association or private institution is so acting without a license, it may either issue a license upon application therefor, or may cause a prosecution to be instituted under the provisions of section 48.41.

48.41 **Penalties.** (1) Any person who shall act as a child welfare agency without a license as provided in this chapter or who shall violate any of the provisions of the statutes relating to the organization, conduct and operations of child welfare agencies, or who in any way, directly or indirectly, offers to place or dispose of any child or hold himself out as being able to place or dispose of children in any manner whatsoever, shall upon conviction thereof be punished by a fine of not less than ten nor more than five hundred dollars or by imprisonment in the county jail for not more than one year, and said term of imprisonment in case of an association or a corporation may be imposed upon its officers who participated in said violation.

Further information in regard to the above matters may be obtained by writing to the Division of Child Welfare, State Capitol, Madison.

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* See page 130 for information in regard to correction and legitimation of the birth record.

† Revisor's note. The state board of control was abolished and the functions thereof transferred to the state department of public welfare by chapter 435, laws of 1939.

Statutes Relating to Producing Abortion or Miscarriage; After-Treatment and Patient Records

WISCONSIN has two statutes of which the first deals with the offense of causing abortion and the second with miscarriage. These statutes are printed here in full.

340.16 **Manslaughter, second degree.** Any person who shall administer to any woman pregnant with a child any medicine, drug or substance whatever, or shall use or employ any instrument or other means with intent thereby to destroy such child, unless the same shall have been necessary to preserve the life of such mother or shall have been advised by two physicians to be necessary for such purpose, shall, in case the death of such child or of such mother be thereby produced, be deemed guilty of manslaughter in the second degree.

351.22 **Producing miscarriage.** Any person who shall administer to any pregnant woman, or prescribe for such woman, or advise or procure any such woman to take any medicine, drug or substance or thing whatever, or shall use or employ any instrument or other means whatever, or advise or procure the same to be used, with intent thereby to procure the miscarriage of any such woman shall be punished by imprisonment in the county jail not more than one year nor less than six months or by fine not exceeding five hundred dollars nor less than two hundred and fifty dollars, or by both such fine and imprisonment in the discretion of the court.

Note that the section relating to miscarriages (a lesser offense) does not contain an express exception for the necessitous circumstances.

After-Treatment

The position of the physician called to treat a patient suffering from the results of an intended and incomplete abortion is a difficult one, and may be precarious as well. Not infrequently the abortionist merely starts the abortion, advising the woman to consult her own physician for all future care. If the woman dies, suspicion may well turn to those near at hand, and the innocent physician may find himself involved in unfortunate publicity as a result of his attendance on the patient at the time of death.

The most satisfactory course would involve the patient's complete disclosure of the facts to the proper authorities, but this is often difficult, if not impossible, of accomplishment. The woman obviously wishes to conceal her condition and its cause, and not infrequently does so until death. While the physician may properly urge such disclosure, he is not himself burdened with that responsibility for he must be ever mindful of those principles which make the welfare of the patient his chief concern.

When a physician is confronted with this type of case, he can, and should, insist that at least one other physician be called in before treatment is given. Preferably, and for obvious reasons, the consulting physician should not be one associated with the attendant physician. Their joint testimony as to the woman's condition would almost invariably negative the charge that any operation performed in the course of treatment was itself an abortion.

In an emergency case, when no other physician is available, it is proper to insist upon the patient signing a written statement, in the presence of witnesses, if possible, reciting the facts with reference to the performance of the abortion, including the name of the abortionist—such statement to be made with the understanding that the physician may use it in event of his needing it for his protection.

In State v. Law, 150 Wis. 313, a physician called to treat a woman after an abortion refused to take charge of her unless she made a full statement concerning the abortion, which he insisted upon for his own protection and to enable him to institute proper treatment. The Supreme Court of Wisconsin said: "It was a very proper request for him to make under the circumstances." Thus there is judicial recognition, by the highest court in Wisconsin, that it is proper for a physician to take precautionary steps to protect himself in such a situation.

NEGLIGENT HOMICIDE

"Negligent homicide" is the designation given to a new statutory offense created by the 1941 Legislature. Contained in section 340.271 of the Wisconsin statutes, the new law provides that any "person who by operation of any vehicle while under the influence of alcoholic beverages or narcotic drugs" or who "by the operation of any vehicle at an excessive rate of speed, or in a careless, reckless or negligent manner, constituting or amounting to a high degree of negligence, but not wilfully or wantonly," shall cause the death of another, shall be deemed guilty of negligent homicide. If guilty of the offense under the first condition stated above, a penalty up to five years' imprisonment, or a fine up to $2,500, or both, may be imposed, while under the last condition, the penalty is up to one year's imprisonment, or a fine up to $1,000, or both.

1942 Federal Wage and Salary Regulations

ON OCTOBER 28, 1942, Hon. James F. Byrnes, Director of Economic Stabilization, issued Salary and Wage Regulations under the authority of Amendments to the Emergency Price Control Act of 1942, dated October 2, 1942, and Executive Order 9250, issued October 3, 1942. These Regulations cover only employers of more than eight persons with certain exceptions not here pertinent.

Your office or clinic is therefore not subject to these Regulations unless, at the time some question of wage or salary increase or decrease arises, you have more than eight employees.

A physician practicing alone, or in association with one or more partners (who may be on regular drawings or shares but *not* on salaries), is not to be counted in determining whether there are more than eight employees, since such a physician or physicians are considered to be self employed. The term "employees" in a medical office or clinic would include: a salaried physician who is not a partner, technicians, nurses, office employees, and a person who does the cleaning of an office or clinic. As the Regulations now stand relatively few physicians or their employees are subject to their terms. The Regulations will apply only to larger partnerships and clinics.

Below are summarized those portions of the Regulations which appear to have special application to physicians and clinics. Because the machinery of the National War Labor Board (hereafter called "WLB") and of the Treasury, which are the two administrative agencies involved, is both new and incomplete, many of the orders and interpretations are subject to sudden and substantial changes, until administration becomes more stabilized.

(1) *Effective Date as to Wages.* The Regulations are effective as to increases and decreases in "wages" (by which is meant compensation computed on an hourly, daily, piece work, or other comparable basis), where such increases or decreases occurred after October 3, 1942, with certain exceptions later noted.

(2) *Effective Date as to Salaries.* As to salaries of less than $5,000, the Regulations are operative as of October 27, 1942, both as to increases and decreases. As to salaries over $5,000, the Regulations are effective as of October 3, 1942. The principal exceptions to this general rule are later noted.

(3) *Authority of War Labor Board.* The National War Labor Board has authority over all wage payments and over all salary payments not in excess of $5,000 per annum, where a given employee is represented by a duly recognized or certified labor organization in his relations with his employer, or is not employed in a bona fide executive, administrative or professional capacity. Authority over salaries of less than $5,000 paid employees who are not represented by a labor organization, or who are employed in a bona fide executive, administrative, or professional capacity, is vested by the Regulations in the U. S. Treasury.

(4) *Effect of WLB Determinations.* Any determination by WLB that a given wage or salary payment is in contravention of the Emergency Price Control Act of 1942 is binding upon all executive departments and agencies of the Government, including the Treasury. Thus, the disallowance of an increase or decrease in wages, or of a salary, coming within the limits noted in paragraph (3) above, would have a direct effect upon deductible wages and salaries for income tax, social security, and other fiscal purposes.

Any determination of the WLB made pursuant to the authority conferred by the salary regulations is final and not subject to review by the recently created tax court of the United States or by any court in any civil proceedings.

It was unofficially announced subsequent to the issuance of the above Regulations that the finality of WLB's determinations was limited to findings of fact, and that conclusions of law remained open to judicial review. Since the *facts* will in essence be the *law* in wage and salary situations, this really offers less for review than there now is under workmen's compensation and other administrative actions.

(5) *Authority of United States Treasury.* The Commissioner of Internal Revenue is given jurisdiction over salary payments which are in excess of $5,000 per annum, together with lesser salaries not subject to the jurisdiction of the WLB, and his determinations are binding on all other executive departments and agencies of the Government and have the same finality and freedom from judicial review as in the case of WLB.

(6) *Increases in Salaries and Wages.* Salary or wage increases, whether the annual rate be less or more than $5,000, are deemed in contravention of the Regulations excepting as the Regulations and subsequent rulings or orders may permit. The effect of this provision is to forbid increases, except as hereafter noted, in any wage, or of a salary of more than $5,000 after October 3, 1942, and of a salary of less than $5,000 after October 27, 1942, with the following exceptions:

(a) In accordance with the terms of an agreement or rate schedule,

(b) As a result of:

(1) Individual promotion and reclassification
(2) Individual merit increases within established wage or salary rate ranges
(3) Operation of an established plan of increases based on length of service
(4) Increased productivity under incentive plans

(5) Operation of a trainee system

(6) Such other reasons or circumstances as may be prescribed in orders, rulings, or regulations promulgated under the authority of the Salary Regulations of October 28, 1942 (as to salaries only)

(c) Where such increase does not result in any substantial increase in the level of costs, or furnish the basis either for increasing price ceilings of the commodity involved or for resisting otherwise justifiable reductions in such price ceilings.

It is important to note that all three of the above conditions must be present before there can be a valid, automatic increase in salaries or wages.

(7) *Decreases in Salaries Under $5,000.* No decrease is permitted below the highest salary rate paid between 1/1/42 and 9/15/42, for a salary of less than $5,000, unless to correct gross inequities or to aid in the prosecution of the war. Any such decrease shall be considered a violation of the 1942 act and of the Wage and Salary Regulations if made prior to approval of WLB or the Treasury.

In the case of salaries under $5,000 which are subject to the authority of the Commissioner of Internal Revenue, decreases do not require his approval where the new salary rate does not fall below the highest rate existing between January 1 and September 15, 1942 for the particular work in question; or where an employee has been demoted to a lower position than that filled by him between the above dates and the salary rate for the lower position is not less than the highest rate existing for that position during the same period; or where an employee has been relieved of substantial duties and responsibilities.

(8) *Decreases in Wages.* The WLB will not approve any decrease in wages for any particular work below the highest wages paid for such work between 1/1/42 and 9/15/42, unless to correct gross inequities and to aid in the effective prosecution of the war. No wage decreases are valid which do not have the approval of the WLB.

(9) *Decreases in Salaries Over $5,000.* A salary which was $5,000 or more on 10/3/42 may be reduced without such reduction being considered a violation of the act and the Regulations unless the new salary, after the decrease, is less than $5,000, in which case the validity of the decrease below $5,000 shall be determined by the WLB or the Treasury under the rules indicated in paragraph (6) above.

(10) *Salary Limitations.* No amount of salary, including all salaries received from two or more employers, shall be paid, authorized or accrued to the account of any employee, or received by him during the taxable year, which, after reduction for federal income and victory taxes on the amount of such salary, would exceed $25,000. This places a ceiling on salaries of approximately $67,200. Relief is permitted in cases of undue hardship arising by reason of heavy life insurance programs, the payment of fixed obligations, charities, federal income taxes for prior years, and like cause.

(11) *Bonuses.* It should be noted that bonuses, gifts, and other forms of additional "compensation" are included within the terms "salaries" and "wages." This does not forbid the payment of a "customary bonus."

The Treasury Department has ruled that as to compensation under its jurisdiction, a bonus or other form of additional compensation based upon a fixed percentage of gross or net profits or receipts of the employer which exceeds in rate of computation or in amount, (even though the rate of computation be unchanged or reduced), the bonus or other form of additional compensation to such employee for the last bonus year ending before October 3, 1942, constitutes a salary increase under the regulations which requires approval by the Commissioner.

It has also been ruled that a payment of bonus based upon a fixed percentage of salary where the percentage has not been changed does *not* require approval by the Commissioner of Internal Revenue even though the amount may be increased due to an authorized increase of salary.

(12) *Limitation of Insurance Deduction.* Sums paid as premiums on group insurance policies, and on the individual insurance policies of employees, where the employer is *not* a beneficiary, is permitted as part of gross salary or wages, except that the amount deductible in the case of a given employee may not exceed 5 per cent of the employee's annual salary or wages determined without the inclusion of insurance benefits.

(13) *Voluntary Wage Increases.*

A. *Before 10/3/42.* WLB has approved all increases in wage rates which were put into effect on or before 10/3/42, reserving the power to disapprove any such wage rate which it may find to be inconsistent with the policy enunciated in Executive Order 9250 or in the Regulations of 10/28/42. In case of such disapproval, discontinuance of further payment of such increased wages may be ordered. Such increases must have been included in a written agreement entered into or communicated to the employee by formal action on or before October 3 and must have been applicable to work done prior to that date, even though such increases are first reflected in a payroll subsequent to October 3. The same holds for salaries under WLB authority, except that the effective date is 10/27/42.

B. *Increases agreed to before but effective after 10/3/42.* In the case of increases in wage rates agreed to before October 3 which did not go into effect until a future date, all such increases require WLB approval if they are payment for work done after October 3.

C. *Increases between 10/3/42 and 11/7/42.* In the case of employers who gave wage increases between October 3 and November 7, 1942, who can show good faith, and lack of knowledge of the provisions

of Executive Order 9250, such employer may ask WLB approval for the increases before December 1, 1942. If the Board advises that the increase was in accordance with its wage policy and approves such increase, the approval will be made retroactive as of the date it went into effect.

This procedure is not applicable to increases in salaries under $5,000 which are under WLB authority. In *all* such cases raises subsequent to 10/27/42 must have the approval of WLB to be valid.

D. *Overtime.* The Treasury has ruled that payment for overtime will constitute an increase in salary rate and thus will require the approval of the Commissioner, unless the customary practice of the employer has been to pay for overtime and the rate has not been changed.

E. *Future Increases.* No changes in wage rates, unless otherwise exempted, are to be made in the future without approval of WLB, even if called for in a collective bargaining agreement. This includes contracts calling for automatic adjustments tied to changes in the cost of living.

(14) *Hiring New Workers.* New workers cannot be hired at more than the established rate or salary in the office or other organization, such established rate to be that which was in effect on October 3 in the case of wages, and October 27 in the case of salaries under $5,000 which are subject to the WLB.

(15) *War Work and Nonwar Work.* The Wage and Salary Regulations have equal application whether a given employer is engaged in *war work* or in *nonwar work.*

(16) *Freezing of Wage and Salary Rates for Job Classifications.* The hiring of an individual at a wage or salary rate in excess of that previously established in an office or clinic for employees of similar ability within the classification within which the individual is employed, is a "wage increase" or a "salary increase," within the meaning of Executive Order 9250, and the Regulations of 10/28/42.

If a wage or salary rate for a job classification has not hitherto been established by the employer involved (i.e., where a new type of job or salaried position has been established for the first time) the rate shall be fixed at a level not exceeding that which prevails for similar classifications within the area, unless a higher rate is approved by WLB.

(17) *Penalties.* If any wage or salary payment is made in contravention of the Amendment of October 2, 1942, or of the Regulations dated October 27, 1942, or of any rulings or orders promulgated thereunder, as determined by the WLB or the Commissioner of Internal Revenue, as the case may be, two penalties are provided. *This means either increases or decreases.*

The *first* is that the *entire* amount of such payment shall be disregarded by all agencies of the federal government in determining the *costs* or *expenses* of any employer for the purpose of any law or regulation, or any maximum price regulation, or for the purpose of calculating deductions under the Revenue laws of the United States, or for the purpose of determining any cost of any contract made by or on behalf of the United States.

The *second* penalty is the liability of the corporation to criminal prosecution and to a fine of as much as $1,000, and imprisonment of the guilty officer or officers for as much as one year, or both.

Comment. Without considering for the moment the criminal aspects of violation, you can see how severe the civil penalties are. If you increased a certain salary from $10,000 a year to $11,000 a year, in violation of the Regulations, the government would not merely disallow the $1,000 increase but the *gross payment of $11,000 for income tax* purposes.

(18) *No Ceiling on Professional Fees.* Although neither the act as amended, the Regulations of 10/28/42, nor any known published supplementary regulations or orders deal expressly with the point, it has been stated unofficially that there is no ceiling on professional fees. This conclusion would be warranted from the definition of "wages" and "salary" contained in the Regulations, and also from the further provision which imposes limitations on the basis of employment and employers. Obviously one who is *self employed,* whether he pays himself from a regular drawing account or not, is *not* an *employee* and receives neither a *wage* nor a *salary.*

It is thus very much to your financial interest and peace of mind to follow very carefully the act, Regulations and all subsequent rulings, orders and interpretations in connection with wage and salary limitations.

MEDICAL LIBRARY SERVICE

Members of the Society may obtain loan packets on any medical topic they wish to study.

All of the current medical journals received by the State Medical Society on an exchange basis, and the medical text books reviewed in *The Journal* "Bookshelf," are given to the Medical Library Service and then become available to any physician in Wisconsin who indicates his desire to use them. All that is required is for the physician to advise the Medical Library Service that he wishes a loan packet on the specific subject he wishes to study. Packets, for example, may be obtained on: acute appendicitis, treatment of fractures of femur, medical or surgical treatment of ulcers, poisons in industry and many others.

Address as follows: Medical Library Service, Service Memorial Institute Building, North Charter Street, Madison, Wisconsin.

Services of the State Board of Health

District Health Offices

The state has been divided into nine districts by the State Board of Health with a full time medical officer in charge of public health activities in each district. An advisory public health nurse, sanitary engineer and secretary make up the staff in each office. The personnel of these offices is available upon request for consultation on any questions pertaining to public health, control of communicable disease, public health nursing or sanitation. A list of the district health offices, medical director and the counties included in each district follows:

District Office No. 1—State Office Building, Madison
Health Officer—Dr. Arthur R. Zintek

Counties included:

Crawford	Columbia	Lafayette
Richland	Dane	Iowa
Sauk	Green	Grant

District Office No. 2—Municipal Bldg., Elkhorn
Health Officer—Dr. Raymond E. Nelson

Counties included:

Jefferson	Walworth	Kenosha
Rock	Milwaukee	Racine
Waukesha		

District Office No. 3—Court House, Fond du Lac
Health Officer—Dr. V. A. Gudex

Counties included:

Winnebago	Dodge	Fond du Lac
Sheboygan	Manitowoc	Ozaukee
Calumet	Washington	

District Office No. 4—City Hall, Sparta
Health Officer—Dr. C. W. Meinershagen

Counties included:

La Crosse	Vernon	Marquette
Waushara	Juneau	Green Lake
Monroe	Adams	

District Office No. 5—Armory, Wisconsin Rapids
Health Officer—Dr. Arthur L. Van Duser

Counties included:

Pepin	Wood	Jackson
Clark	Trempealeau	Portage
Buffalo	Marathon	

District Office No. 6—City Hall Annex, Green Bay
Health Officer—Dr. Allan Filek

Counties included:

Waupaca	Door	Marinette
Kewaunee	Oconto	Outagamie
Shawano	Brown	

District Office No. 7—Box 36, Chippewa Falls
Health Officer—Dr. F. P. Daly

Counties included:

Polk	Rusk	St. Croix
Dunn	Chippewa	Eau Claire
Barron	Pierce	

District Office No. 8—P. O. Box 269, Rhinelander
Health Officer—Dr. Frances Cline

Counties included:

Taylor	Oneida	Florence
Price	Forest	Langlade
Lincoln	Vilas	

District Office No. 9—Vaughn Lib. Bldg., Ashland
Health Officer—Dr. M. W. Meyer

Counties included:

Douglas	Washburn	Sawyer
Burnett	Ashland	Iron
Bayfield		

Communicable Diseases

Quarantinable diseases.—Cerebrospinal meningitis (epidemic), cholera (Asiatic), diphtheria, infantile paralysis, plague, scarlet fever, smallpox, typhus fever, yellow fever.

Placardable diseases.—Chickenpox, influenza, leprosy, measles, German measles, typhoid fever, whooping cough.

Reportable only.—Erysipelas, infectious encephalitis, mumps, ophthalmia neonatorum, pneumonia (lobar), trachoma, tuberculosis, malaria, amebic dysentery, epidemic sore throat, tularemia and undulant fever.

Reporting of cases.—A physician is required to report to the health officer in writing within twenty-four hours all cases of communicable disease. Sec. 143.04. (All suspicious cases must be reported and treated as positive until a correct diagnosis can be made. Any neglect or refusal of a physician or householder to report cases of communicable disease makes him liable to a severe fine.)

Privilege under quarantine.—Physicians are among the few individuals specified by law as permitted to enter premises quarantined for communicable disease. The expense of maintaining quarantine, including examinations and tests for disease carriers, provided this is done under direction of the local board of health, and the enforcement of isolation, shall be paid by the town, village or city, but the expense in treating communicable disease is not necessarily an obligation of the local board of health, and the local authorities cannot be held liable unless prior arrangement has been made with the physician. Sec. 143.05.

Vaccination for smallpox.—When vaccination or exclusion from school is ordered in times of epidemic, with an actual case or cases in the community in a communicable form, the local board of health shall provide for the free vaccination of all children in any school district or part thereof during such outbreak, the expense to be borne by the district. Parents may employ physicians of their choice to perform such vaccinations and shall pay the expense incurred. Sec. 143.13 (3).

Venereal disease.—All physicians and certain institutions are required to report directly to the State Board of Health all persons with venereal disease in a communicable state who come to them for treatment. Sec. 143.07.

A printed form, serially numbered, furnished by the State Board of Health, is used for reporting. Printed instructions for the patient are attached to this report blank and are required to be given to him. Secrecy is imposed upon the State Board. Sec. 143.07.

The State Board of Health requires that the source of infection be investigated and reported back to the Board for the purpose of investigation. All persons having a venereal disease must remain under treatment until the disease is no longer communicable. Discontinuing treatment may be the cause for commitment to an institution until the disease is no longer communicable. Investigation in cases not under treatment may be made by an officer of the State Board of Health, or, when so directed by the State Board of Health, by any local health officer who is a physician. Sec. 143.07 (2), (4), (5).

Drugs commonly used for treatment of syphilis are furnished by the State Board of Health on request to physicians submitting morbidity reports as required by the U. S. Public Health Service. Physicians having patients unable to pay for treatment for venereal disease may assign such individuals to state clinics for treatment.

When a patient refuses treatment the physician shall notify the State Board of Health, giving particulars, to enable the Board to act, and, if necessary, to have the person committed for treatment. In counties of over 250,000 population, the county board may designate the county institution where such commitments may be made. Such persons may be summoned before any court of record or a warrant may be issued for them. Sec. 143.07(5).

When a physician has reported a case of venereal disease to the State Board of Health, all questions regarding the presence of the disease and the date from which treatment was neglected shall not be regarded as privileged information when the patient or physician is called upon to testify to the facts before any court of record. Sec. 143.07(7).

Physicians shall be furnished free of charge with the results of examinations for the diagnosis of gonorrhea made by any state laboratory, and of examinations of blood or secretions for the diagnosis of syphilis from the Wisconsin Psychiatric Institute. Sec. 143.07 (10).

Any city or county may require that persons convicted of acts involving moral turpitude shall undergo a medical examination for the presence of a venereal disease.

No physician or health officer shall issue a certificate of freedom for any person except those certificates required by law for marriage licenses and those required by local ordinances to be issued to local health officers. No person shall carry or exhibit such certificates to other persons, or show, for immoral purposes, venereal disease reports from any laboratory.

All cases of venereal disease shall be regarded as communicable until the following requirements have been met: Until open sores are healed; until satisfactory care and treatment have been given pregnant women with syphilis, females who have given birth to a syphilitic child, syphilitic persons at any stage of the disease who reasonable evidence indicates are promiscuous in sexual relations and are a menace to others, and persons with early syphilis not adequately treated. Trained public health nurses and health officers are available to physicians in the state, from the State Board of Health, for finding and holding cases of venereal disease.

Physician protected from liability.—A physician who reports to the State Board of Health the name of a person afflicted with a venereal disease on account of such person not continuing treatments until the disease is no longer communicable will be protected from liability, if the facts justify his action. 8 Atty. Gen. 561.

Infant blindness.—The attending physician (or midwife) is required to use a 1 per cent silver nitrate solution in the eyes of newborn babies. For the prevention of ophthalmia neonatorum the State Board of Health is required to supply the solution free to every physician (and midwife), put up in proper containers and distributed to health officers for delivery to practitioners.

When ophthalmia neonatorum appears in any newborn babe not attended by a physician or midwife and the case is reported, as required, to the health officer, a competent physician shall be employed by the municipality to examine and treat the infant as directed in the instructions accompanying the solution. The penalty for violation of any part of this law is a fine up to $100. Sec. 146.01.

Laboratory examination for venereal disease.—The state laboratory of hygiene and branch and cooperative laboratories shall make microscopical examinations for the diagnosis of gonorrhea, and the Psychiatric Institute the necessary examinations of blood or secretions for the diagnosis of syphilis, for any physician in the state, without charge.

Venereal disease, indigents. — The county is required to pay for the care and treatment of indigent persons afflicted with a venereal disease. 8 Atty. Gen. 559.

The county is responsible for one-half of the per capita cost for the care and treatment of indigents committed to state institutions for the treatment of venereal disease. Sec. 143.07 (6).

Tuberculosis.—Every physician is required to report within one week cases of tuberculosis in his care or under his observation. The report shall contain the name and address, age and sex of the case. Report blanks will be furnished by the State Board of Health.

Voluntary admission to a tuberculosis sanatorium in Wisconsin can be obtained (Chapter 50) by having the patient or his representative appear before a county judge and the district attorney of his legal settlement for a determination of the patient's legal settlement and general financial ability. Report of the examining physician and judge's orders are transmitted to the sanatorium where the patient may be admitted by the superintendent when a vacancy occurs.

Compulsory commitment to a tuberculosis sanatorium may be made (Chapter 143.06) by a county judge provided that the patient has been shown to have violated the rules and regulations of the State Board of Health pertaining to tuberculosis.

Maternal and Child Health

Lecturers for Medical Societies.—The Bureau of Maternal and Child Health has a special fund through which $20 is available by special arrangement to medical societies toward payment for lecturers in the field of obstetrics, pediatrics, and preventive mental health. Trained specialists on the staff of the Bureau are also available for group talks or consultations.

Incubators.—Incubators have been placed at strategic points throughout the state and are available for the home care of premature babies. Physicians anticipating premature deliveries at home, or after such deliveries, can make arrangement for the use of an incubator through the local public health nurse or the district health office. The public health nurse can then demonstrate the use of the incubator and supervise the nursing care of the baby at the physician's request.

Prenatal Letter Service.—Many physicians in the state routinely use the prenatal letter service of the Bureau. Slips for enrolling patients are available. Any mother enrolled for this service receives letters at monthly intervals as well as other educational material on prenatal and infant care ("Prenatal Care," "Health Habits for Pregnancy," "Why Should the Expectant Mother Have a Blood Test Made During Her Pregnancy?" "Infant Care," "Diet and Development Cards" for the first year, "Establishing Good Food Habits," "Are You Having Your Sunbaths and Cod Liver Oil?").

The wall card "Health Habits for Pregnancy" and the "Diet and Development Cards" also may be obtained by physicians for general distribution to their office patients. "Diet and Development Cards" are also available covering the preschool years.

State Laboratory of Hygiene

Physicians shall be furnished free of charge with results of laboratory analyses of specimens sent for determining diagnosis of disease. Laboratories are located at Madison, Rhinelander, Oshkosh, Green Bay, Superior, Beloit, Kenosha, Wausau, Sheboygan and La Crosse.

The materials which are examined in these laboratories are sputum for tubercle bacilli; swabs for diphtheria bacilli and other organisms; pus for gonococci and other organisms; central nervous systems of dogs and other animals for Negri bodies diagnostic of rabies; spinal fluid for meningococci and other organisms; materials in suspected cases of anthrax, glanders and actinomycosis; blood, feces and urine for the diagnosis of typhoid and paratyphoid fever (blood only for tularemia and undulant fever) or to detect carriers of these germs; and chemical and bacteriologic examination of water to detect its fitness for drinking purposes. The examination of tissue in suspected cases of malignancy is done only in the laboratory in Madison, and only in those cases wherein the patients are unable to pay a special fee. Such tests are made free for physicians, and the facilities of the laboratories are urged upon the physicians of Wisconsin in the effort to detect and combat communicable disease. Pneumonia typing is now a valuable service offered by the laboratories.

State biologic products.—Under the law, local boards of health are required, under the direction of the State Board of Health, to furnish antitoxin to indigents suffering from communicable diseases. The State Laboratory of Hygiene at Madison has available for distribution free of charge to physicians in the state typhoid-paratyphoid vaccine and whooping cough vaccine. Tuberculin diluted 1 to 1,000 is available for group testing by the Mantoux test.

Vital Statistics

Registration with local registrars.—Upon locating for the practice of medicine, physicians are required to register their name, address and occupation with the local registrar of vital statistics, and by him be supplied with the laws, rules and regulations for the enforcement of the vital statistics law. Sec. 69.17.

Registration of births.—Physicians shall file within five days certificates of births attended by them. Such reports are to be made to the local registrar of the district in which the births occur. All particulars shall be given in the space provided. All bills or charges for professional services rendered in connection with confinements are declared unlawful unless the birth certificate, properly filled out, is reported within five days. Sec. 69.26.

Physician's Handbook.—The Board of Health distributes a Physician's Handbook on birth and death registration available from the Bureau of Vital Statistics on request.

Delayed birth registration.—If a birth is not reported within the first year after birth, it falls into the classification of delayed birth registration, and then it requires supplementary documentary proof, even though a legally executed birth certificate is submitted at that time. Two or three documents are necessary for filing a delayed birth record depending upon whether or not one of them is a class A document (one that has been executed within the first four years of life). One of the documents in each case must establish parentage, and each must establish the date and place of birth. It is not necessary that any of them, in a case of delayed registration, be signed by the attending physician. These are federal regulations, issued by the Army, Navy and Census Bureau, as well as being required by state law.

Illegitimate births.—In the case of a child born out of wedlock, the physician shall not fill in the name of the supposed father until legal proceedings shall have adjudged the paternity of the child.

Chapter 524, Laws of 1939, provides that a new certificate shall be made out in cases of illegitimate birth when the parents are subsequently married or when the child is subsequently adopted. This new certificate is to contain no reference to the illegitimacy or adoption. The original certificate is to be filed and may not be obtained thereafter except on court order.

Certificate of birth before child is named.—When a certificate of birth is presented without the given name, the local registrar shall make out and deliver to the parents a special blank for the supplemental report of such given name. The certificate should be filed with the local registrar within the five day period required, even though the child has no name at that time. Sec. 69.30.

Stillbirths; registration required.—The 1941 legislature changed the law regarding reporting of stillbirths. These are being reported on a special certificate, instead of being reported separately as births and deaths. This will allow more specific questions to be asked pertaining directly to the causes of stillbirth. It will allow more detailed studies to be made on this subject along the lines of those recently made from the additional material obtained from the lower portion of the new birth certificates.

Publications

The following publications are available through the Wisconsin State Board of Health, State Office Building, Madison, Wisconsin:

Medical Publications of Interest to Physicians

Gonorrhea in the Female
Maternal Care
Maternal Care Complications
Periodic Health Examination
Standard Treatment Procedure in Early Syphilis
Syphilis in Mother and Child
The Appraisal of the Newborn Infant
The Management of Syphilis in General Practice

Departmental Publications

General

Accident Prevention
Activities of the Wisconsin State Board of Health
Biennial Report
Cancer
Good Teeth (for children)
Good Teeth (for parents)
Health Officer's Guide*
Household Pests
Manual and Directory of Wisconsin Hotels*
Manual and Directory of Wisconsin Restaurants*
The Family Physician
The Wisconsin Registered Nurse Bulletin
Vital Statistics Law
Wisconsin Funeral Directors and Embalmers Laws, Rules and Directory
Wisconsin State Board of Health Quarterly Bulletin
Wisconsin State Laboratory of Hygiene Rules and Regulations

Communicable Diseases

After Care of Infantile Paralysis
An Ordinance to Regulate and Control the Sale and Distribution of Milk, Cream, Buttermilk, and Skimmed Milk
Athlete's Foot
Diphtheria
Infantile Paralysis
Measles
Prevention and Control of Communicable Diseases
Prevention of Diphtheria
Rabies
Regulations and Recommendations Relating to the Sanitary Care of Schools and Control of Communicable Diseases
Scarlet Fever
Smallpox
The Prevention and Control of Communicable Skin Diseases and Pediculosis
The Tuberculin Test
Tuberculosis
Typhoid Fever
Undulant Fever
Vital Information Concerning the Prevention and Control of Communicable Diseases (chart)
Whooping Cough

Social Hygiene

A Church Program for Defense Areas
Are You Being Played for a Sucker?
Child Questions and Their Answers—for parents
Choosing a Home Partner—for young people
Defense on the Venereal Disease Front
Facts About Syphilis, Gonorrhea and Other Venereal Diseases
Gonorrhea
Health for Your Baby and You
Health Helps
Hidden Costs in Industry
Industrial Aspects of Venereal Disease Control
Keeping Fit—for boys and young men
Know For Sure
Parents Are the Child's First and Best Social Hygiene Teachers
Syphilis
Syphilis and Your Town
The A–B–C of Syphilis
The Dentist Can Find Syphilis

* Limited number available.

The Doctor Says
The Girl's Part—for girls fourteen years and up
The Mother's Reply—for parents
The Place of Sex Education in Biology and General Science—for teachers
The Story of Two Men with Syphilis
Twenty Questions on Gonorrhea
Venereal Disease and National Defense
What to Read on Social Hygiene
You Can End This Sorrow

Industrial Hygiene
Bill Gets the Works
But Flu is Tougher
Clara Gives Benzol the Run Around
KO by CO Gas
Leonard's Appendix—and How It Burst
List of First Aid Equipment
Oral Manifestations of Occupational Disease According to Occupation (3 charts)
Photo-Roentgenography
Protecting Plant Manpower
Suggestions for the Guidance of the Nurse in Industry
Syphilis is Bad Business
Syphilis is Everybody's Problem (pay envelope insert)
Trouble in the Midriff
Until the Doctor Comes
Wisconsin Physical Examination Program
Who's Too Small for a Health Program

Maternal and Child Health
Are You Training Your Child to be Happy
Child From One to Six
Child Management
Constipation Control
Diet and Development Cards
Months 1 and 2
Months 3 and 4
Months 5, 6, and 7
Months 8 to 12
Years 1 and 2
Years 2 to 6
Directions for Making Shoulder Garters
Establishing Good Food Habits
Food For School Girls and Boys
Good Posture (under 6)
Guiding the Adolescent
Health Habits for Pregnancy
Infant Care
Keeping the Well Baby Well
Knitting Directions for Wool Soakers
Maternity Belt Pattern
Mother! Nurse Your Baby
Out of Babyhood Into Childhood
Prenatal Care
Prenatal Letters
Preparing Liver for the Young Child
Request Cards for Listed Publications
Suggestions for Preparing Eggs for Children
Sun Baths and Cod Liver Oil
Take Care of Your Eyes
The Expectant Mother
The Family's Food (wall card)
Tonsils and Adenoids
Vitamins—Minerals
Your Child's Sleep

Sanitary Engineering
Annual Report
Cross Connections in Plumbing and Water Supply Systems
Effects of Pulp and Paper Mill Wastes on Fish
Lake and Stream Platting and Sanitation Code
Methods of Cement Grouting for Sanitary Protection of Wells
Methods of Treating Cannery Waste
Progress Report on Sanitary Engineering and Stream Pollution Control Activities
Public Water Supplies in Wisconsin
Report on Chemical Treatment of Lakes and Streams
Sanitary Regulations for Various Kinds of Camps
Semi-Annual Report
State Plumbing Code
Stream Pollution in Wisconsin
Studies of Pulp and Paper Mill Wastes
Studies of Swimmer's Itch and Its Control
Wisconsin State Well Drilling Code
Wisconsin Swimming Pools and Bathing Places
Wisconsin Swimming Pool and Recreational Bathing Code

Films of Interest to General Public

As part of the general health education program the Wisconsin State Board of Health has purchased or produced the following 16 mm. films. These films are loaned free to doctors, schools, and public health agencies. If projectors or operators are not available, arrangements can be made for the showing of films through the District Health Offices. It is necessary to use a sound projector for the showing of sound films. Requests for films should be sent to the Wisconsin State Board of Health, Madison, Wisconsin.

Communicable Diseases

1. **The Control and Eradication of Syphilis.** Twenty minutes, sound film. Prepared by the U. S. P. H. S., covering the problems involved in the control of syphilis. For public education. Not a "horror picture," but a public health problem presented.

2. **Let's Open Our Eyes.** Thirteen minutes, sound film. On syphilis. For public education. Film describing the natural history of syphilis and the devastating effects of the disease together with its cost to the public. Suitable for any type of audience. No genital lesions are shown. Dignified and effective.

3. **With These Weapons.** Thirteen minutes, sound film. The latest and most up-to-date film on syphilis, its natural history, and its social complications. Excellent photography and composition suitable for any audience whether mixed or otherwise.

4. **In Defense of the Nation.** Thirteen minutes, sound film. Emphasizing the importance of protecting military personnel and defense industry personnel from the vicious influences that may contribute to venereal disease.

5. **Plain Facts.** Thirteen minutes, sound film. On syphilis and gonorrhea combined and certain fundamental facts concerning the two diseases.

6. **Behind the Shadows.** Thirteen minutes, sound film. On the epidemiology of tuberculosis. For public education. Illustrates value of tuberculin test and roentgenography in early discovery of tuberculosis.

7. **Let My People Live.** Thirteen minutes, sound film. On tuberculosis. For public education. Film on tuberculosis meant for negroes but very popular be-

cause of its splendid music from the play, "Green Pastures." Setting at Tuskegee Institute. Very good —simple language although dialect.

8. **Cloud in the Sky.** Twenty minutes, sound film. On tuberculosis. Designed for Spanish-speaking people but might possibly prove of interest because of the excellent music. A good film on tuberculosis for public education. English translation.

9. **Good Bye Mr. Germ.** Twenty minutes, sound film. On tuberculosis. Intended for school children of elementary grades but also a favorite with adult groups.

10. **On the Firing Line.** Twenty-five minutes, sound film. For mature people, especially those interested in the broad program of tuberculosis prevention. Gives a bird's eye view of the tuberculosis situation in the United States.

11. **Tuberculosis.** Thirteen minutes, sound film. Film designed to promote a general understanding of tuberculosis, its nature, prevention, diagnosis, treatment and after-care. Suitable for both classroom or general public.

General

1. **Choose to Live.** Twenty minutes, sound film. On cancer. For public education.

2. **Your Public Health Nurse.** Fifteen minutes, sound film. Activities of the public health nurse including committee work, work in school, bedside care and teaching in the home.

3. **Your Health Department.** Twenty minutes, sound film. This picture takes a typical small-town family and shows through different steps how a well developed modern health department would affect their lives. Briefly, it covers the premarital examination, nursing care for the expectant mother during and after delivery, immunization of the children and quarantine for communicable diseases, dental hygiene, health education in the schools, milk inspection and restaurant inspection, work of the industrial hygiene division, and free distribution of drugs and biologic supplies.

4. **School Days in the Country.** Seventeen minutes, sound film. Directed to the rural teacher and all who must cooperate with her in carrying out a successful health program. Filmed in typical country schools, it pictures health problems common to the one and two room school, gives practical suggestions for solving them and for making the best use of equipment and facilities at hand, shows how health behavior is improved through practice in everyday living, and how the teacher's guidance of each pupil makes for his continuous progress toward optimum physical and mental development.

5. **First Aid, Wounds and Fractures.** Fifteen minutes, sound film. Concepts presented in the film include the need for first-aid knowledge in everyday life, determining the nature and extent of injuries, summoning medical help, prevention of hemorrhage, applying splints, and avoiding shock. Can be best used for groups from the intermediate grade level upward.

6. **Save a Day.** Twelve minutes, sound film. This film shows the services of industrial hygiene studies in protecting the health and safety of industrial workers. It is particularly applicable at this time by stressing the need for conservation of manpower of our central war industries.

Maternal and Child Health

1. **Judy's Diary Series:** Part I. From Morning Until Night. Thirty minutes, silent film. Routine day of a six-month old child, including bath and meals.

Part II. By Experience I Learn. Twenty minutes, silent film. Growth and development of Judy between nine and eighteen months of age.

Part III. Now I Am Two. Twenty-three minutes, silent film. Routine day of Judy at two years; includes experiences with playmates.

2. **Play's the Thing.** Fifteen minutes, silent film. A child's development is aided by wisely chosen toys. Much valuable play equipment may be inexpensively made at home.

3. **Child Growth and Development.** Forty-five minutes, sound film. Developmental attainments at twelve, thirty-six, and fifty-four weeks.

4. **Early Social Behavior.** Twenty-five minutes, sound film. The infant gains acquaintance with himself, his environment, and the people in it.

5. **Motherhood; Life's Most Important Job.** Fifteen minutes, silent film. Proper diet, early and regular medical care in pregnancy, cleanliness and adequate rest and recreation.

6. **Prenatal Care.** Fifteen minutes, silent film. Health habits for the expectant mother.

7. **Food and Growth.** Fifteen minutes, silent film. A sixth grade class feeding experiment with white rats, comparing the food value of milk with that of coffee and candy.

8. **The Road to Health and Happiness.** Fifteen minutes, silent film. Dental examination and health and hygiene film showing effective way to care for the mouth, teeth and body. Excellent for junior high and high school students.

9. **The Life of a Healthy Child.** Fifteen minutes, silent film. Health habits of the school child: cleanliness, correct diet, safety, visits to dentist and physician, play at home and in school. Good for grade school students.

10. **Smiles Have It.** Fifteen minutes, sound film. Deals with diet, exercise, rest, and general health principles as they relate to dental health. Especially adapted for use in schools, and of value in health education for adult lay groups.

11. **Value of a Smile.** Fifteen minutes, sound film. Deals with diet, exercise, rest, and general health principles as they relate to dental health. Especially adapted for use in schools, and of value in health education for adult lay groups.

12. **For Health and Happiness.** Fifteen minutes, sound film. This is an attractive colored film showing well developed, active children, and emphasizing the factors contributing to good health. This film

would be satisfactory to finish a general talk on health of children in the preschool period or in the early grades.

Films of Interest to Physicians

Communicable Diseases

1. **A Clinic on Syphilis.** Seventy minutes, sound film. Prepared by AMA, USPHS, and cooperative clinics for physicians showing clinics on diagnosis, primary and secondary syphilis, latent syphilis, congenital syphilis, syphilis in pregnancy, neurosyphilis, syphilis and public health. Physicians speaking—Stokes, Cole, McCord, O'Leary, Moore, Jeans, Venderlehr, Parran, Fishbein.

2. **Syphilis of the Central Nervous System.** Twenty minutes, silent film. For physicians. Covering the diagnosis of the central nervous system syphilis.

3. **Gonorrhea in the Male.** Thirty-five minutes, silent film. For physicians. Showing treatment of gonorrhea. Much diagrammatic material.

4. **Syphilis.** Sixty minutes, sound film. A motion picture in natural color and sound for the information of physicians and medical students. Can be shown in part or *in toto* to suit the time or audience.

5. **Pneumonia.** Thirteen minutes, sound film. Designed to show the course of a typical case of pneumonia treated according to modern methods from the time of infection until the cure. Both drug and serum treatment are demonstrated, as well as nursing care.

6. **The Early Care of Poliomyelitis.** Twenty-four minutes, silent film. Dr. Blount's film. Shows the early care for infantile paralysis.

Obstetric

1. **Appraisal of the Newborn.** Twenty-four minutes, sound film. This film emphasizes the importance of careful and adequate appraisal of the physical condition of the infant during the neonatal period and describes and demonstrates each step of the medical examination. It calls attention to the value of a careful history which considers the socio-economic background of the family, past history, family history, and a detailed history of antepartum, intrapartum and postpartum periods.

2. **Asphyxia of the Newborn.** Twenty-four minutes, silent film. Dr. DeLee's film. Shows first, the wrong methods of resuscitation, then the approved methods, as the aspiration of nasopharyx, intratracheal catheter, mouth-to-mouth breathing, and the methods of reviving the heart action in severe asphyxia.

3. **Postpartum Hemorrhage.** Twelve minutes, silent film. Shows the various methods of treatment on patients and models.

4. **Treatment of Breech Presentation.** Forty-eight minutes, silent film. Dr. DeLee's film. The diagnosis of breech presentation, spontaneous version and external version. Normal delivery of breech with manual aid; a complete breech extraction with forceps on the aftercoming head, first on a manikin with fetus, then on a primipara. Treatment of asphyxiated baby.

5. **Forceps Delivery.** Forty-eight minutes, silent film. Dr. DeLee's film. Gives the history of forceps, the indications and conditions for the operation. Shows episiotomy and low forceps, manual rotation and forceps, and forceps in occiput posterior position, all illustrated by models, animated drawings, pelvis and fetal head, etc.

6. **Eclampsia.**—Thirty-six minutes, silent film. Dr. DeLee's film. Shows prenatal care, a case of mild toxemia, one of eclampsia imminens, a patient with convulsions and exophthalmic goiter and shows autopsy findings of mother and baby; another case of convulsions, treatment, and recovery.

7. **Standard Obstetrical Routine.** One and a half hours, silent film. Mennen film. Demonstrates diagnosis of position and presentation by abdominal and rectal examination. The conduct of labor is well demonstrated, showing delivery technic, conduct of the third stage, and how episiotomies and lacerations are repaired. The last part of the film deals with nursery care, emphasizing careful individual care of babies.

FILM STRIPS PROVE A GREAT AID

When called upon to appear before public audiences, physicians will find the film strips, lanterns and manuscripts available from the State Medical Society a very genuine aid. These are furnished to members on a loan basis without cost.

The films which are available are as follows:

"A Public Address on Cancer"—This film was prepared by the Committee on Cancer of the State Medical Society for presentation by physicians to lay groups. The film consists of a number of still pictures, with accompanying monologue recording, on cancer.

"Health Achievements in Wisconsin"—This film was prepared by the Committee on Health and Public Instruction to portray the work of the Society in disease prevention and control and in the advancement of the public health. This consists of 100 still pictures dealing with the public health legislation sought by the Society, the training that is required to become a physician and the health problems confronting us in Wisconsin.

"Emergency Medical Service"—This film was prepared by the Office of Civilian Defense. It consists of a film strip and phonograph record showing the operation of Emergency Medical Service during an air raid. This provides a 30 minute program. In addition to the facilities supplied by the State Medical Society, it will be necessary to use a portable phonograph, or obtain a special unit available from Ford International Harvester Dealers.

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Prof. Robert N. Bauer, Secretary, 3414 W. Wisconsin Ave., Milwaukee
Prof. William H. Barber, Treasurer, 621 Ransom Ave., Ripon

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State Board of Health

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Mr. Arnold Spencer, Supervisor
Sanitary Engineering
Mr. L. F. Warrick, State Sanitary Engineer
Well Drilling
Mr. Louis Watry, Supervisor
Editor
Mr. John Culnan

District Health Officers

1. Madison—Arthur R. Zintek, M. D., 348 State Office Building
2. Elkhorn—R. N. Nelson, M. D., Municipal Building
3. Fond du Lac—V. A. Gudex, M. D., Court House
4. Sparta—(Temporary vacancy)
5. Neillsville—(Temporary vacancy)
6. Green Bay—Arthur Van Duser, M. D., City Hall Annex
7. Chippewa Falls—F. P. Daly, M. D., Rutledge Charities Building
8. Rhinelander—Frances Cline, M. D., City Hall
9. Ashland—M. W. Meyer, M. D., Vaughn Library Building

State Board of Public Welfare

(Created by act of 1939 legislature to supplant the State Board of Control, and combining certain other agencies.)

Members of the Board

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Mrs. Erma Stoddart, Beaver Dam, Vice-Chairman
Mr. Herman A. Kloppmann, Crivitz
Mr. Frank W. Wabiszewski, Milwaukee
(Three vacancies)

Executive Staff

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Mr. A. W. Bayley, Madison, Executive Secretary, and Assistant to Director
Division of Corrections:
Mr. Morris G. Caldwell, Ph.D., Director

Division of Mental Hygiene:
Mr. W. J. Urban, Madison, Director

Division of Public Assistance:
Mr. George M. Keith, Madison, Director

Division of Administration and Research:
Mr. H. B. Evans, Madison, Acting Director

Division of Child Welfare:
Miss Elizabeth Yerxa, Madison, Director

Division of Adult Blind Services:
Mr. E. F. Costigan, Madison, Director

Division of Pre-Pardon Procedure:
Miss Lila Burton, Director

Wisconsin Industrial Commission

Members of the Commission
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Mr. Harry J. Burczyk
Mr. C. L. Miler
Miss Helen Gill, Secretary

Workmen's Compensation Department
Mr. Harry A. Nelson, Director

Unemployment Compensation Department
Mr. Paul Raushenbush, Director

Safety and Sanitation Department
Mr. Robert MacA. Keown, Director

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Menomonie

President-Elect
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810 Main Street
Racine

Secretary
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917 Tenney Building
Madison

Assistant Secretary
Mr. George B. Larson
917 Tenney Building
Madison

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Dr. I. R. Sisk
1 South Pinckney Street
Madison

Speaker, House of Delegates
Dr. Charles Fidler
231 West Wisconsin Avenue
Milwaukee

Vice-Speaker
Dr. P. R. Minahan
110 North Washington Street
Green Bay

Councilors*
(Dr. S. E. Gavin, Fond du Lac, Chairman)

First: Dodge, Jefferson and Waukesha County Societies. Dr. A. G. Hough, Beaver Dam, 1945.

Second: Kenosha, Racine and Walworth County Societies. Dr. C. E. Pechous, 625 Fifty-seventh Street, Kenosha, 1945.

Third: Dane, Columbia–Marquette–Adams, Green, Rock and Sauk County Societies. Dr. W. T. Clark, 20 East Milwaukee Street, Janesville, 1943.

Fourth: Crawford, Grant, Iowa, Lafayette and Richland County Societies. Dr. B. I. Pippin, Richland Center, 1943.

Fifth: Calumet, Manitowoc, Sheboygan and Washington–Ozaukee County Societies. Dr. A. H. Heidner, West Bend, 1943.

Sixth: Brown–Kewaunee–Door, Fond du Lac, Outagamie and Winnebago County Societies. Dr. S. E. Gavin (chairman), 104 South Main Street, Fond du Lac, 1943.

Seventh: Juneau, La Crosse, Monroe, Trempealeau–Jackson–Buffalo and Vernon County Societies. Dr. H. A. Jegi, Galesville, 1944.

Eighth: Marinette–Florence, Oconto and Shawano County Societies. Dr. G. W. Krahn, Oconto Falls, 1944.

Ninth: Clark, Green Lake–Waushara, Lincoln, Marathon, Portage, Waupaca and Wood County Socities. Dr. H. H. Christofferson, Colby, 1944.

Tenth: Barron–Washburn–Sawyer–Burnett, Chippewa, Eau Claire–Dunn–Pepin, Pierce–St. Croix, Polk and Rusk County Societies. Dr. R. G. Arveson, Frederic, 1944.

Eleventh: Ashland–Bayfield–Iron and Douglas County Societies. Dr. T. J. O'Leary, 1507 Tower Avenue, Superior, 1945.

Twelfth: The Medical Society of Milwaukee County. Dr. Robert W. Blumenthal, 411 East Mason Street, Milwaukee, 1943; Dr. R. E. Fitzgerald, 2750 North Teutonia Avenue, Milwaukee, 1945; Dr. C. W. Eberbach, 324 East Wisconsin Avenue, Milwaukee, 1945.

* Map indicating location of councilor districts, page 137.

Thirteenth: Forest, Langlade, Oneida–Vilas and Price–Taylor County Societies. Dr. J. W. Lambert, Antigo, 1944.

Dr. Gunnar Gundersen (Past-President), 1836 South Avenue, La Crosse, 1943.

Delegates to American Medical Association

Dr. S. E. Gavin (1944)
104 South Main Street
Fond du Lac

Commander J. C. Sargent (1944)
U. S. Naval Training Station
San Diego, California

Dr. J. F. Smith (1943)
605½ Third Street
Wausau

Alternates

Dr. L. O. Simenstad (1944)
Osceola

Dr. A. E. Rector (1944)
103 West College Avenue
Appleton

Dr. C. W. Giesen (1943)
1507 Tower Avenue
Superior

STANDING COMMITTEES

The Committee on Cancer

Dr. Charles Fidler, 1943, chairman, 231 West Wisconsin Avenue, Milwaukee
Dr. L. J. Van Hecke, 1944, 231 West Wisconsin Avenue, Milwaukee
Dr. A. L. Mayfield, 1944, 625 Fifty-Seventh Street, Kenosha
Dr. C. F. Dull, 1944, Richland Center
Dr. J. C. Fox, 1944, 401 Main Street, La Crosse
Dr. W. S. Bump, 1944, Rhinelander
Dr. Julius Blom, 1944, Woodville
Dr. T. E. Malloy, 1945, Random Lake
Dr. J. W. McGill, 1945, 1225 Tower Avenue, Superior
Dr. E. F. Schneiders, 1943, 113 North Carroll Street, Madison
Dr. T. A. Teitgen, 1943, 927 South Eighth Street, Manitowoc
Dr. Erich Wisiol, 1943, 441 Main Street, Stevens Point
Dr. G. E. Eck, 1945, Lake Mills
Dr. D. J. Twohig, 1945, 11 North Main Street, Fond du Lac

The Advisory Committee on Care of Crippled Children

Dr. J. B. MacLaren, 1944, chairman, 120 South Oneida Street, Appleton
Dr. H. A. Sincock, 1945, 1507 Tower Avenue, Superior
Dr. H. L. Greene, 1944, 1 South Pinckney Street, Madison
Dr. J. O. Dieterle, 1943, 425 East Wisconsin Avenue, Milwaukee
Dr. H. C. Schumm, 1943, 425 East Wisconsin Avenue, Milwaukee
Dr. C. M. Kurtz, 1945, 1300 University Avenue, Madison

The Committee on Coordination of Medical Services

Dr. C. O. Vingom, 1944, chairman, 122 West Washington Avenue, Madison
Dr. Millard Tufts, 1943, 208 East Wisconsin Avenue, Milwaukee
Dr. S. E. Gavin, 1945, 104 South Main Street, Fond du Lac
President, ex officio
Secretary, ex officio

The Committee on Goiter

Dr. Arnold S. Jackson, 1945, chairman, 16 South Henry Street, Madison
Dr. O. R. Lillie, 1943, 208 East Wisconsin Avenue, Milwaukee
Dr. F. G. Anderson, 1944, 314 East Grand Avenue, Eau Claire
Dr. E. L. Sevringhaus, ex officio, 1300 University Avenue, Madison
Dr. C. N. Neupert, ex officio, State Office Building, Madison

The Committee on Grievances

Dr. A. E. Rector, 1943, chairman, 103 West College Avenue, Appleton, (alternate member)
Dr. Louis Fauerbach, 1944, 16 North Carroll Street, Madison
Dr. W. A. Ryan, 1943, 709 North Eleventh Street, Milwaukee
Dr. A. J. Patek, 1945, 425 East Wisconsin Avenue, Milwaukee

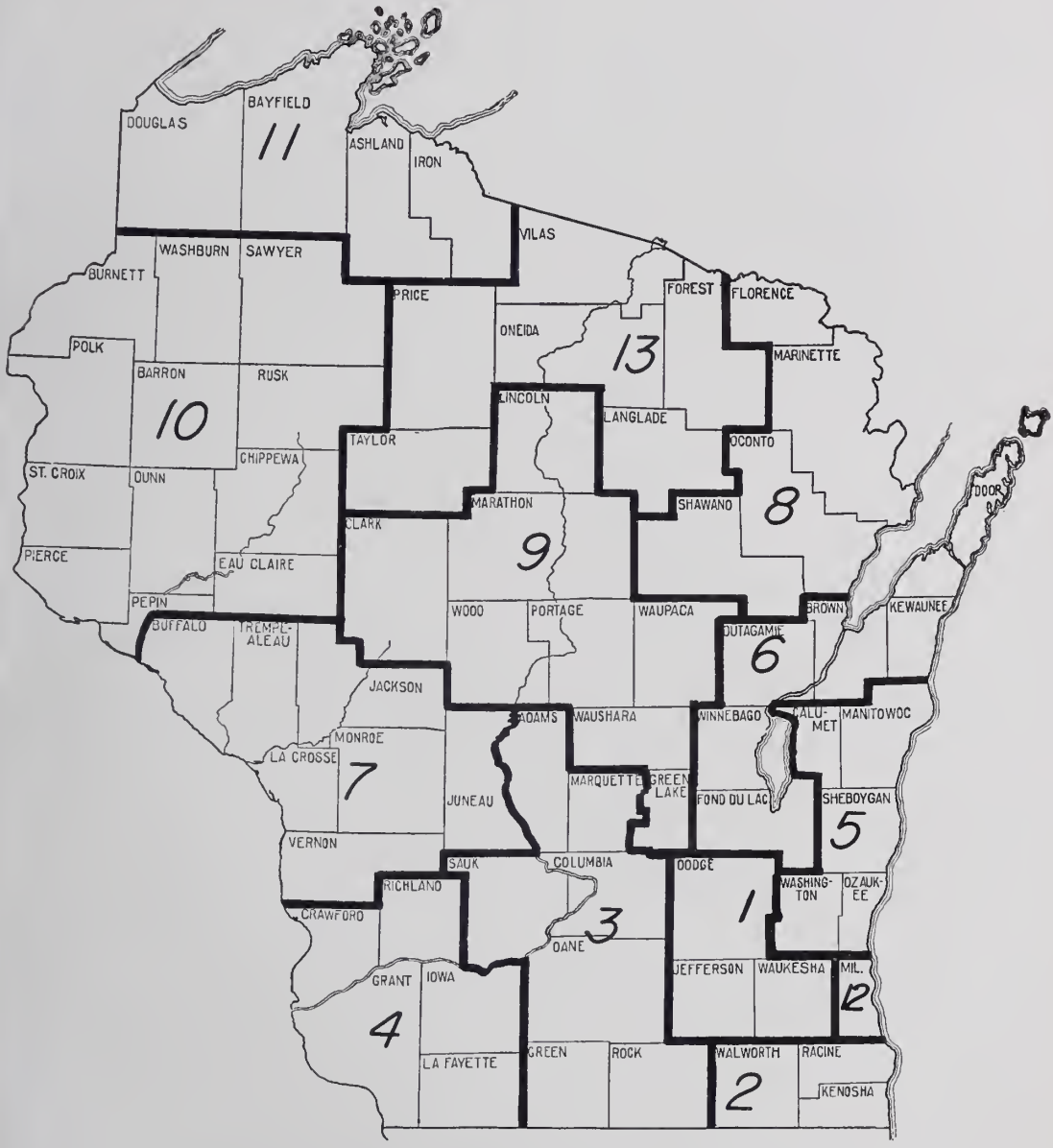
The Committee on Health and Public Instruction

Dr. W. J. Egan, 1943, chairman, 720 North Jefferson Street, Milwaukee
Dr. C. J. Newcomb, 1944, 411 East Mason Street, Milwaukee
Dr. G. W. Krahn, 1945, Oconto Falls

The Committee on Hospital Relations

Dr. J. E. Habbe, 1945, chairman, 231 West Wisconsin Avenue, Milwaukee
Dr. W. H. Jaeschke, 1945, Wisconsin General Hospital, Madison
Dr. R. M. Waters, 1944, 1300 University Avenue, Madison
Dr. M. L. Jones, 1943, 510½ Third Street, Wausau
Dr. E. O. Gertenbach, 1943, 425 East Wisconsin Avenue, Milwaukee
Dr. Gorton Ritchie, 1944, St. Mary's Hospital, Racine

(Continued on page 138)



MAP INDICATING LOCATION OF COUNCILOR DISTRICTS

First District:
Dr. A. G. Hough, Beaver Dam

Second District:
Dr. C. E. Pechous, Kenosha

Third District:
Dr. W. T. Clark, Janesville

Fourth District:
Dr. B. I. Pippin, Richland Center

Fifth District:
Dr. A. H. Heidner, West Bend

Sixth District:
Dr. S. E. Gavin, Chairman
Fond du Lac

Seventh District:
Dr. H. A. Jegi, Galesville

Eighth District:
Dr. G. W. Krahn, Oconto Falls

Ninth District:
Dr. H. H. Christofferson, Colby

Tenth District:
Dr. R. G. Arveson, Frederic

Eleventh District:
Dr. T. J. O'Leary, Superior

Twelfth District:
Dr. C. W. Eberbach, Milwaukee
Dr. R. E. Fitzgerald, Milwaukee
Dr. Robert W. Blumenthal, Milwaukee

Thirteenth District:
Dr. J. W. Lambert, Antigo

COMMITTEES—Continued

The Committee on Industrial Health

Dr. Gunnar Gundersen, 1945, chairman, 1836 South Avenue, La Crosse
Dr. H. L. Greene, 1943, 1 South Pinckney Street, Madison
Dr. T. J. Howard, 1944, 716 North Eleventh Street, Milwaukee
Dr. L. W. Hipke, ex officio, 425 East Wisconsin Avenue, Milwaukee

The Committee on Maternal and Child Welfare

Dr. A. C. Radloff, 1945, chairman, Plymouth
Dr. J. Gurney Taylor, 1944, 324 East Wisconsin Avenue, Milwaukee
Dr. J. J. Pink, 1943, 324 East Wisconsin Avenue, Milwaukee
Dr. J. W. Harris, 1945, 1300 University Avenue, Madison
Dr. Amy Louise Hunter, 1944, State Capitol, Madison
Dr. J. F. Wilkinson, 1943, Oconomowoc

The Committee on Medical Economics and Voluntary Sickness Insurance

Dr. D. H. Witte, 1945, chairman, 3405 West Lisbon Avenue, Milwaukee
Dr. F. G. Anderson, 1945, 314 East Grand Avenue, Eau Claire
Dr. L. D. Quigley, 1944, 207 East Walnut Street, Green Bay
Dr. T. A. Leonard, 1944, 110 East Main Street, Madison
Dr. Robert Krohn, 1943, Black River Falls
Dr. A. C. Taylor, 1943, 103 West College Avenue, Appleton

The Committee on Medical Education and Hospitals

Dr. F. D. Murphy, 1945, chairman, 536 West Wisconsin Avenue, Milwaukee
Dr. P. A. Midelfart, 1944, 314 East Grand Avenue, Eau Claire
Dr. R. E. Burns, 1943, 1300 University Avenue, Madison

The Committee on Mental Hygiene and Institutional Care

Dr. H. H. Christofferson, 1944, chairman, Colby
Dr. B. J. Hughes, 1945, Winnebago
Dr. S. K. Pollack, 1943, 208 East Wisconsin Avenue, Milwaukee

The Committee on Public Policy

Dr. C. A. Dawson, 1945, chairman, River Falls
Dr. S. E. Gavin, 1944, 104 South Main Street, Fond du Lac
Colonel J. C. Sargent, 1943, U. S. Naval Training Station, San Diego, California
President, president-elect, secretary—ex officio
Gunnar Gundersen, 1943, 1836 South Avenue, La Crosse (alternate member)

The Council on Scientific Work

Dr. E. R. Schmidt, 1944, chairman, 1300 University Avenue, Madison
Dr. G. W. Krahn, 1942, Oconto Falls
Dr. F. D. Murphy, 1944, 536 West Wisconsin Avenue, Milwaukee
Dr. C. J. Smiles, 1943, Ashland
Dr. K. H. Doege, 1945, Marshfield
Dr. W. S. Middleton, ex officio, 1300 University Avenue, Madison
Dr. E. J. Carey, ex officio, 561 North Fifteenth Street, Milwaukee
Dr. C. D. Niedhold, 1945, 103 West College Avenue, Appleton

The Committee on Tuberculosis and Chest Diseases

Dr. L. O. Simenstad, 1943, chairman, Osceola
Dr. G. D. Reay, 1944, 324 Main Street, La Crosse
Dr. A. A. Pleyte, 1945, 1018 North Jefferson Street, Milwaukee

The Advisory Committee on Visual and Hearing Defects

Dr. F. S. Cook, 1945, chairman, 131 South Barstow Street, Eau Claire
Dr. J. K. Trumbo, 1944, 520 Third Street, Wausau
Dr. F. W. Kundert, 1943, Monroe

The Advisory Committee to Woman's Auxiliary

Chairman of Council, chairman
Immediate past-president
President
President-elect
Secretary

COMMITTEES OF HOUSE OF DELEGATES

The Committee to Study Problems Relating to the Medical Practice Act

Dr. R. G. Arveson, chairman, Frederic
Dr. E. J. Carey, 561 North Fifteenth Street, Milwaukee
Dr. W. S. Middleton, 1300 University Avenue, Madison (in service)
Dr. C. A. Dawson, River Falls
Dr. C. D. Neidhold, 103 West College Avenue, Appleton
Dr. H. M. Coon, Wisconsin General Hospital, Madison (alternate member)

The Committee on Nursing Problems

Dr. W. A. Munn, chairman, 19 South Main Street, Janesville
Dr. H. M. Stang, 314 East Grand Avenue, Eau Claire
Dr. Burton Clark, Jr., 11 Algoma Boulevard, Oshkosh
Dr. F. A. Stratton, 324 East Wisconsin Avenue, Milwaukee

COMMITTEES OF THE COUNCIL

(Appointed in January annually by chairman of the Council)

The Auditing Committee

Dr. H. H. Christofferson, Colby
Dr. G. W. Krahn, Oconto Falls
Dr. Henry J. Gramling, 2750 West Forest Home Avenue, Milwaukee

The Executive Committee

Chairman of Council, chairman
Dr. W. T. Clark, 20 East Milwaukee Street, Janesville
Dr. A. H. Heidner, West Bend
Dr. Robert W. Blumenthal, 411 East Mason Street, Milwaukee
President, ex officio
President-elect, ex officio
Treasurer, ex officio
Secretary, ex officio

The Conference Committee on Open Panels

Representing the State Medical Society of Wisconsin
Dr. T. J. O'Leary, Superior, chairman
Dr. R. M. Kurten, Racine
Representing the Association of Casualty and Surety Executives (stock insurance companies)
Mr. E. E. Langworthy, Milwaukee
Representing the American Mutual Alliance
Mr. C. W. Kroening, Wausau

The Conference Committee on Wisconsin Hospitals and Medical Payments Plan

Representing the Association of Casualty and Surety Executives
Mr. E. E. Langworthy, Milwaukee, chairman
Mr. A. D. Kehoe, Milwaukee
Representing the American Mutual Alliance
Mr. C. W. Kroening, Wausau
Mr. H. J. Schroeder, Stevens Point
Representing the State Medical Society of Wisconsin
Dr. C. H. Andrew, Platteville
Dr. A. E. Rector, 103 West College Avenue, Appleton
Representing the Wisconsin Hospital Association
Miss Grace Crafts, Madison
Representing the Wisconsin Conference of Catholic Hospitals
Sister Mary Bernadette, Madison

Constitution and By-Laws of the State Medical Society of Wisconsin*

CONSTITUTION

ARTICLE I

NAME OF THE ASSOCIATION

The name and title of this organization shall be the State Medical Society of Wisconsin.

ARTICLE II

PURPOSE

The purposes of this Society shall be to federate and bring into one compact organization the entire medical profession of the State of Wisconsin, and to unite with similar societies of other states and territories of the United States to form the American Medical Association; to extend medical knowledge and advance medical science; to elevate the standard of medical education, and to secure the enactment and enforcement of just medical laws; to promote friendly intercourse among physicians; and to enlighten and direct public opinion in regard to the great problems of state medicine, so that the profession shall become more capable and honorable within itself, and more useful to the public, in the prevention and cure of disease, and in prolonging and adding comfort to life.

ARTICLE III

COMPONENT SOCIETIES

SECTION 1. Component societies shall consist of those county medical societies which hold charters from this Society.

SEC. 2. The terms, county medical society and component county medical society, shall be deemed to include all county medical societies and academies of medicine now in affiliation with this Society, or which may hereafter be organized and chartered by the House of Delegates of this Society.

ARTICLE IV

COMPOSITION OF THE ASSOCIATION

SECTION 1. This Society shall consist of members who shall be the members of the component county medical societies who have been certified to the headquarters of this Society, and whose dues and assessments for the current year have been received by the secretary.

SEC. 2. Those members who have been elected to honorary membership by the various component county societies may be enrolled as honorary members of this Society upon approval of the Council. These honorary members shall enjoy all the rights of membership, and their dues to the State Society shall be remitted.

SEC. 3. Members in good standing who shall make outright gifts to the Endowment Fund of this Society, in the amount of $1,000 or more, shall have bestowed upon them the gift of life membership in this Society. Such membership shall carry with it all the prerequisites of active membership, without the requirement of annual dues, and shall continue in force during the life of the member, providing that the member continues in good standing in his local county medical society.

ARTICLE V

HOUSE OF DELEGATES

The House of Delegates shall be the legislative body of the Society, and shall consist (1) of delegates elected by the component county medical so-

* As revised by the 1942 House of Delegates.

cieties, and one delegate representing each Section of the Society organized under the By-Laws and (2) the officers of the Society enumerated in Section 1 of Article IX of this Constitution, and past presidents of the Society shall be ex officio members, but without the right to vote.

ARTICLE VI

COUNCIL

The Council shall be the Board of Trustees of this Society. The Council shall have full authority and power of the House of Delegates, between annual sessions, unless the House of Delegates shall be called into session as provided in the Constitution and By-Laws. It shall consist of the councilors and the immediate past president. The president, the president-elect, the secretary, the treasurer and the speaker of the House of Delegates shall be ex officio members of the Council, but without the right to vote. Nine of its members shall constitute a quorum.

ARTICLE VII

SECTIONS AND DISTRICT SOCIETIES

The House of Delegates may provide for a division of the scientific work of the Society into appropriate sections, and for the organization of such councilor district societies as will promote the best interests of the profession, such societies to be composed exclusively of members of component county societies.

ARTICLE VIII

SESSIONS AND MEETINGS

SECTION 1. The Society shall hold an annual session during which there shall be at least two general meetings, open to all registered members, delegates and guests.

SEC. 2. The place for holding each annual session shall be fixed by the House of Delegates, or, by failure to act, such authority is delegated to the Council. The time for holding each annual session shall be approved by the Council.

SEC. 3. Special meetings of either the Society or the House of Delegates may be called by a two-thirds vote of the Council or upon petition by twenty delegates.

ARTICLE IX

OFFICERS

SECTION 1. The officers of this Society shall be a president, a president-elect, a secretary, a treasurer, councilors from thirteen districts, and a speaker and vice speaker of the House of Delegates.

SEC. 2. The officers, except the councilors, shall be elected annually. The terms of the councilors shall be for three years. There shall be elected one councilor for each of the thirteen districts, except that in any councilor district embracing a membership of 250 or more, there shall be elected one additional councilor for each additional 250 members or major fraction thereof.

As nearly as possible, one third of the members of the Council shall be elected each year. The secretary and the treasurer shall be elected by the Council. All these officers shall serve until their successors are elected and installed.

The president-elect shall automatically succeed the office of president at the conclusion of his one-year term of president-elect.

ARTICLE X

FUNDS AND EXPENSES

SECTION 1. Funds shall be raised by an equal per capita assessment on each component society. The amount of the assessment shall be fixed by the House of Delegates. Funds may also be raised by voluntary contributions, from the Society's publications and in any other manner approved by the House of Delegates. The treasurer and secretary shall submit an annual budget to the Council. All resolutions providing for appropriations shall be referred to the Council and all appropriations approved by the Council shall be included in the annual budget.

SEC. 2. The House of Delegates, by adoption of a By-law, may provide for a special classification of members at per capita reduced dues where such classification may be applied generally throughout the state, and has no special application to individual members or to individual societies.

ARTICLE XI

REFERENDUM

At any general meeting of the Society it may, by a two-thirds vote, order a general referendum upon any question pending before the House of Delegates. The House of Delegates may, by a vote of its members, submit any question to the membership of the Society for its vote. A majority vote of all the members of the Society shall determine the question.

ARTICLE XII

SEAL

The Society shall have a common seal. The power to change or renew the seal shall rest with the House of Delegates.

ARTICLE XIII

AMENDMENTS

The House of Delegates may amend any article of this Constitution by a two-thirds vote of the members of the House present at any annual session, provided that such amendment shall have been presented in open meeting at the previous annual session, and that it shall have been published twice during the year in the bulletin or journal of this Society, or sent officially to each component society at least two months before the meeting at which final action is to be taken.

BY-LAWS

CHAPTER I

MEMBERSHIP

SECTION 1. The name of a physician on the official roster of this Society, after it has been properly reported by the secretary of his county society, shall be *prima facie* evidence of membership and of his right to register at the annual session.

SEC. 2. No person who is under sentence of suspension or expulsion from any component society of this Society, or whose name has been dropped from its roll of members, shall be entitled to any of the rights or benefits of this Society.

SEC. 3. Each member in attendance at the annual session shall register, when his right to membership has been verified by reference to the records of this Society. No member shall take part in any of the proceedings of the annual session until he has complied with the provisions of this section of the By-Laws.

CHAPTER II

GENERAL MEETINGS

SECTION 1. The general meetings shall be open to all registered members and guests. At such time as may have been arranged, shall be delivered

the annual addresses of the president and of the president-elect.

SEC. 2. No address or paper, except those of the president, the president-elect, and the annual orations, shall occupy more than twenty minutes in its delivery. No member, except by unanimous consent, shall speak more than once in the discussion of any paper nor longer than five minutes at any one time.

SEC. 3. All papers read before this Society shall be its property. Each paper, when it has been read, shall be deposited with the secretary. Authors of papers read before this Society shall not cause them to be published elsewhere until after they have been published in its Journal or returned by the Editorial Board. Authors who fail to observe this section shall be ineligible to appear on programs of the State Society for a period of five years.

CHAPTER III

HOUSE OF DELEGATES

SECTION 1. The House of Delegates shall meet annually at the time and place of the annual session.

SEC. 2. Each component county society shall be entitled to send each year one delegate or one corresponding alternate to the House of Delegates for each fifty full-paid members or major fraction thereof in this Society provided, however, that each county society shall be entitled to at least one delegate or one corresponding alternate.

For purposes of this section, the number of fully paid members as of a date thirty days in advance of the first session of the House of Delegates at the annual meeting shall determine the number of delegates to which a county medical society may be entitled.

The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 3. One fourth of the members of the House of Delegates registered shall constitute a quorum of the House of Delegates. All meetings of the House of Delegates shall be open to members of the Society.

SEC. 4. From among members of the House of Delegates the speaker of the House of Delegates, for the purpose of expediting proceedings, shall appoint Reference Committees to which reports and resolutions shall be referred as follows:

a. On Credentials.
b. On Resolutions.
c. On Reports of Officers.
d. On Reports of Standing Committees.

He shall also appoint such other committees as may be considered by him to be necessary.

SEC. 5. The House of Delegates shall elect delegates to the House of Delegates of the American Medical Association in accordance with the Constitution and By-Laws of that body.

SEC. 6. The House of Delegates shall divide the State into councilor districts, specifying what counties each district shall include, and, when the best interest of the Society and the profession will be promoted thereby, organize in each a district medical society, of which all members of the component county societies shall be members.

SEC. 7. The House of Delegates shall have authority to appoint committees for special purposes from among members of the Society who are not members of the House of Delegates. Such committees shall report to the House of Delegates, and may be present and participate in the debate on their reports.

SEC. 8. It shall approve all memorials and resolutions issued in the name of the Society before they shall become effective.

SEC. 9. Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates.

CHAPTER IV

ELECTION OF OFFICERS

SECTION 1. The House of Delegates at its first meeting at the annual session shall elect a committee on nominations consisting of one delegate from each councilor district. The committee on nominations shall report the result of its deliberations to the House of Delegates in the form of a ticket containing the names of one or more members for each of the offices to be filled at that annual session. No two candidates for president-elect shall be from the same district. Each candidate for councilor must be a resident of the district for which he is nominated. Nominations for councilor shall be made from the floor and not from the Committee on Nominations.

SEC. 2. The report of the nominating committee and the election of officers shall be the first order of business of the House of Delegates at the third meeting of the House.

SEC. 3. All elections of officers, where more than one nomination is received, shall be by ballot and a majority of the votes cast shall be necessary to elect except for delegates and alternates to the American Medical Association. In case no nominee receives a majority of the votes on the first ballot, the nominee receiving the lowest number of votes shall be dropped and a new ballot taken. This procedure shall be continued until one of the nominees receives a majority of all the votes cast, when he shall be declared elected. In case no delegates or alternates for the American Medical Association receive on the first ballot a majority of the vote, the nominees shall be declared elected in the order of the highest number of votes received, until the allotted number shall have been chosen. In case of a tie vote for delegate or alternate, the tie shall be determined by lot.

SEC. 4. Nothing in this chapter shall be construed to prevent additional nominations being made from the floor by members of the House of Delegates.

SEC. 5. No person known to have solicited votes for or sought any office within the gift of this Society shall be eligible for any office for two years.

CHAPTER V

DUTIES OF OFFICERS

SECTION 1. The president shall preside at all meetings of the Society; he shall appoint a Committee on Arrangements for the annual session and all committees not otherwise provided for; he shall deliver an annual address at such time as may be arranged, and shall perform such other duties as custom and parliamentary usage may require. He shall be the real head of the profession of the State during his term of office, and, as far as practicable, shall visit, by appointment, the various sections

of the State and assist the councilors in building up the county societies, and in making their work more practical and useful.

SEC. 2. The president-elect shall act for the president in his absence or disability. If the office of president should become vacant the president-elect shall succeed to the presidency. In case of vacancy in the office of both president and president-elect the Council shall appoint one of its members as acting president until the next meeting of the House of Delegates.

SEC. 3. The treasurer shall give bond in such amount as the Council may provide. He shall demand and receive all funds due the Society, together with bequests and donations. He shall pay money out of the treasury only on a written order of the secretary; he shall subject his accounts to such examination as the House of Delegates may order, and he shall annually render an account of his doings and of the state of the funds in his hands.

SEC. 4. The secretary shall attend the general meetings of the Society and the meetings of the House of Delegates, and shall keep minutes of their respective proceedings. He shall be secretary of the Council. He shall be custodian of all record books and papers belonging to the Society, except such as properly belong to the treasurer, and shall keep account of and promptly turn over to the treasurer all funds of the Society which come into his hands. He shall provide for the registration of the members and delegates at the annual session. He shall, with the cooperation of the secretaries of the component societies, keep a card index register of all the legal practitioners of the State by counties, noting on each his status in relation to his county society, and shall transmit a copy of this list to the American Medical Association, transmitting to its secretary each month a report containing the names of new members and the names of those dropped from the membership roster during the preceding month. He shall conduct the official correspondence, notifying members of meetings, officers of their election and committees of their appointment and duties. He shall employ such assistants as may be ordered by the Council and shall make an annual report to the House of Delegates. He shall supply all component societies with the necessary blanks for making their annual reports, and shall collect from them the regular per capita assessments and turn the same over to the treasurer. The amount of his salary shall be fixed by the Council.

SEC. 5. The speaker shall preside at the meetings of the House of Delegates and shall perform such duties as custom and parliamentary usage require.

SEC. 6. The vice speaker shall officiate for the speaker in the latter's absence or at his request. In case of death, resignation, or removal of the speaker, the vice speaker shall officiate during the unexpired term.

CHAPTER VI

COUNCIL

SECTION 1. The Council shall meet on the day preceding the annual session, and daily *if necessary* during the session and at such other times as necessity *may* require, subject to the call of the chairman or on petition of three councilors. It shall hold an annual meeting during January for purposes of organization and other business. Its chairman shall make an annual report to the House of Delegates.

SEC. 2. Each councilor shall be organizer, peacemaker and censor for his district. He shall visit each county in his district at least once a year for the purpose of organizing component societies where none exist, for inquiring into the condition of the profession, and to keep in touch with the activities of and to aid in the betterment of the component societies of his district. He shall make an annual report of his work, and of the condition of the profession of each county in his district at the annual session of the Council. The necessary traveling expenses incurred by each councilor in the line of duties herein imposed may be allowed on a proper itemized statement, but this shall not be construed to include his expense in attending the annual session of the Society.

SEC. 3. The Council shall be the executive body of the House of Delegates and between sessions shall exercise the power conferred on the House of Delegates by the Constitution and By-Laws.

The Council shall be the Board of Censors of the Society. It shall consider all questions involving the rights and standing of members, whether in relation to other members, to the component societies, or to this Society. All questions of an ethical nature brought before the House of Delegates or the general meeting shall be referred to the Council without discussion. It shall hear and decide all questions of discipline affecting the conduct of members or component societies, on which an appeal is taken. Its decision in all cases, including questions regarding membership in this Society, shall be final.

SEC. 4. Charters shall be issued to county societies only on approval of the Council, and shall be signed by the president and secretary of this Society. Upon the recommendation of the Council, the House of Delegates may revoke the charter of any component society whose actions are in conflict with the letter or spirit of this Constitution and By-Laws.

SEC. 5. In sparsely settled sections the Council shall have authority to organize the physicians of two or more counties into societies, to be suitably designed so as to distinguish them from district societies, and these societies, when organized and chartered, shall be entitled to all rights and privileges provided for component societies until such counties shall be organized separately.

SEC. 6. The Council shall provide for and superintend the issuance of all publications of the Society including proceedings, transactions and memoirs, and shall have authority to appoint an editor of the Journal and such assistants as it deems necessary. It shall prescribe the methods of accounting and through a committee of three of its members to be known as a Committee on Auditing and Finance, shall audit all accounts of this Society, and with the treasurer, supervise the investment of funds. The Council shall adopt an annual budget providing for the necessary expenses of the Society, which shall be prepared and presented for its consideration by the treasurer and secretary at the first meeting of the Council in January of each year. Its chairman shall submit an annual report to the House of Delegates, which shall specify the character and cost of the publications of the Society, the amount and character of all of its property, and shall provide full information concerning the management of all affairs of the Society which the Council is charged to administer.

SEC. 7. The Council shall, by appointment, fill any vacancy in office not otherwise provided for which may occur during the interval between annual meetings of the House of Delegates; the appointee shall serve until his successor has been elected and has qualified.

SEC. 8. The Council may elect as secretary one who need not be a physician nor a member of the Society.

SEC. 9. The salaries of all employees of the Society shall be fixed by the Council.

SEC. 10. The Council shall provide such headquarters for the Society as may be required to conduct its business properly.

CHAPTER VII

COMMITTEES

SECTION 1. The standing committees of this Society shall be as follows:

A Council on Scientific Work.
A Committee on Public Policy.
A Committee on Grievances.
A Committee on Cancer.
A Committee on Medical Education and Hospitals.
A Committee on Medical Economics and Voluntary Sickness Insurance.
A Committee on Maternal and Child Welfare.
A Committee on Health and Public Instruction.
A Committee on Coordination of Medical Services.
A Committee on Care of Crippled Children.
A Committee on Goiter.
A Committee on Visual and Hearing Defects.
A Committee on Mental Hygiene and Institutional Care.
A Committee Advisory to the Woman's Auxiliary.
A Committee on Tuberculosis and Chest Diseases.
A Committee on Industrial Health.
A Committee on Hospital Relations.

Unless otherwise provided in these By-Laws, each of these committees shall consist of three members, each of whom shall serve for a term of three years. One member of each of these committees shall be appointed annually by the incoming president, by and with the consent of the House of Delegates, provided that where the House creates a new standing committee the original appointments shall be for terms of one, two, and three years, and thereafter for terms of three years each.

SEC. 2. The Council on Scientific Work shall consist of five members, and each member shall serve for a period of five years. The Council on Scientific Work shall study the character and scope of the scientific proceedings of the Society and shall prepare the scientific program for the annual meeting. It shall likewise study the field of postgraduate education, making available, so far as lies within its power, program material for such postgraduate education both through programs of component societies and in such other ways as it may find feasible. It shall also be in charge of the affairs of the Journal. Important questions of editorial policy shall be submitted to the Council of the Society and an annual report shall be made to the House of Delegates.

SEC. 3. The Committee on Public Policy shall consist of three members, and the president, the president-elect and secretary. The committee shall present to those public officers charged with the duty of enacting or enforcing measures in the interest of public health, all available information that may in any way assist such officers honorably to discharge their responsibilities.

SEC. 4. The Committee on Grievances shall investigate all reported claims against members for compensation for injuries said to have resulted from malpractice. It shall determine as nearly as may be practicable the circumstances leading up to the making of the claim itself and the grounds on which the claim is based. The committee shall recommend to the Society from time to time such measures as it deems practicable for the limitation or removal of the causes of such claims. It may, at the request of any member against whom a claim has been made, place at his disposal such evidence as becomes available to the committee. If the committee believes a claim unjust, it shall, at the request of the member against whom the claim has been made, cooperate, so far as it can lawfully do so, with him and his counsel in defense against it. If the committee believes that the claim that it has investigated is a just claim, the committee may, at the request of the member against whom the claim was made, cooperate with him and his counsel, so far as it lawfully can do so, in effecting an equitable settlement. The committee shall submit a report of its proceedings at each annual meeting of the Society, covering the preceding year, in which report shall be included all recommendations made by the committee during the year looking toward the removal of the causes of claims based on alleged malpractice.

SEC. 5. The Committee on Medical Education and Hospitals shall serve in this State for the Council on Medical Education and Hospitals of the American Medical Association, and shall have referred to it all questions pertaining to hospitals and medical education.

SEC. 6. The Committee on Medical Economics and Voluntary Sickness Insurance shall be charged with the responsibility of reporting annually to the House of Delegates such recommendations as may, in its judgment, seem proper with reference to the subject of medical economics and voluntary sickness insurance. The committee shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be anpointed for a term of one year, two members for a term of two years, and two members for a term of three years each.

SEC. 7. The Committee on Maternal and Child Welfare shall consist of six members and its principal duties shall be to advise cooperating agencies in the effort to reduce maternal mortality and to preserve child health.

SEC. 8. The Committee on Health and Public Instruction shall consist of three members. It shall carry on such activities in the field of health and the dissemination of information in relation thereto as the House of Delegates and Council may direct.

SEC. 9. The Committee on Care of Crippled Children shall consist of six members, and its principal duty shall be to act in an advisory capacity to state departments concerned with the subject matter.

SEC. 10. The Committee on Goiter shall consist of three members, and its principal duty shall be to forward those measures looking toward the prevention of goiter, and where existent, its early diagnosis and treatment.

SEC. 11. The Committee on Visual and Hearing Defects shall consist of three members, and its principal duties shall lie in the field of prevention, and where existent, early discovery and treatment. It shall act in an advisory capacity to state departments concerned with these problems.

SEC. 12. The Committee on Mental Hygiene and Institutional Care shall consist of three members, and its principal duties shall be advisory to both the Society and cooperating agencies as to those means best designed to protect mental health and to alleviate mental illnesses.

SEC. 13. The Committee Advisory to the Woman's Auxiliary shall consist of the chairman of the Council, the immediate past-president, the president, the president-elect, and the secretary. Its principal

duties shall be to advise state officers of the Auxiliary, particularly in the field of approval of new projects.

SEC. 14. The Committee on Tuberculosis and Chest Diseases shall consist of three members, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of tuberculosis and diseases of the chest.

SEC. 15. The Committee on Industrial Health shall consist of three members, and its principal duties shall be to cooperate with the Council on Industrial Health of the American Medical Association, and to seek to further the health of those employed in industry in Wisconsin.

SEC. 16. The Committee on Hospital Relations shall consist of six members, and each member shall serve for a period of three years. Of the original appointments, two members shall be appointed for a term of one year, two members for a term of two years, and two members for a term of three years, and thereafter for terms of three years each. The principal duty of this committee shall be to consider, investigate and study the interrelationship of the medical profession to the hospital institutions, and to act in an advisory capacity to the Society.

SEC. 17. The Committee on Cancer shall consist of a member appointed from each of the councilor districts of the State Society, and its principal duties shall be advisory to the Society and cooperating agencies as to those means best designed to aid in the prevention and alleviation of cancer. As nearly as possible, the terms of one-third of the members of the committee shall expire each year, with each committee member being appointed for a term of three years.

SEC. 18. Reports of the standing and special committees shall be published in the official Journal preceding the date of the annual session of this Society, and these reports must be in the hands of the secretary sixty days in advance of the annual session.

CHAPTER VIII

DUES AND ASSESSMENTS

SECTION 1. The annual dues and assessments shall be determined by the House of Delegates, and shall be levied per capita on the members of the Society. They shall be payable on or before January 1 of the year for which they are levied. The secretary of each component society shall cause to be collected and shall forward to the offices of the Society the dues and assessments for its members, together with such data as shall be required for a record of its officers and membership. Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted.

An active member who shall have attained his eightieth year and shall have been a member of his county medical society in Wisconsin or elsewhere in the United States continuously since beginning the practice of medicine, or who for fifty years shall have been continuously a member of his county medical society in Wisconsin or elsewhere in the United States, shall, upon establishing the above facts to the satisfaction of his county society, and upon the recommendation of such society, be granted the status of a life member. Such member shall enjoy full membership privileges, and shall be exempt from the payment of further dues or assessments, and a certificate of special membership shall be issued to him annually.

An active member in good standing in his county society may, upon the recommendation of such society, be granted affiliate membership with full voting and other privileges where one or more of the following conditions exists: retirement from practice; physical or other disability of a character preventing the practice of medicine; a serious and prolonged illness; or financial reverses. Affiliate membership shall be on an annual basis only, and a member must be recommended each year for such special status by the secretary and president of his county medical society following a review and reassessment of his particular situation. An affiliate member shall enjoy full membership privileges and shall be exempt from the payment of dues and assessments during the year in which he is granted such status, and a certificate of membership shall be issued to him for such year.

An active member in good standing in his county society who has for thirty-five continuous years been a member of this State Society shall receive a special certificate and plaque indicating the completion of such period of membership.

SEC. 2. The record of payment of dues and assessments on file in the offices of the Society shall be final as to the fact of payment by a member and as to his right to participate in the business and proceedings of the Society and of the House of Delegates.

SEC. 3. Any county society which fails to make the reports required, at least thirty days before the annual session of the State Society, shall be held suspended, and none of its members or delegates shall be permitted to participate in any of the proceedings of the Society or of the House of Delegates.

CHAPTER IX

The ethical principles governing the members of the American Medical Association shall govern members of this Society. No member shall profess adherence or give support to any exclusive dogma, sect or school.

CHAPTER X

The deliberations of this Society, except as may be provided otherwise in the Constitution and By-Laws, shall be conducted in accordance with parliamentary usage as defined in Roberts' Rules of Order.

CHAPTER XI

SECTION 1. All county societies now in affiliation with the State Society or those that may hereafter be organized in this State, which have adopted principles of organization not in conflict with this Constitution and By-Laws shall, upon application to the Council, receive charters from this Society, provided that their constitutions and by-laws shall have been submitted to the Council and received its approval.

SEC. 2. Only one component medical society shall be chartered in each county.

SEC. 3. Each county society shall judge of the qualifications of its members, subject to review and final decision by the Council of the State Society. Every reputable and legally qualified physician who is a citizen of the United States and who is a bona fide resident of the same county shall be eligible to apply for membership so long as he does not practice nor profess to practice sectarian medicine, or engage in practice in a manner in conflict with the Principles of Ethics of the American Medical Association, or so conduct himself as to defeat the purposes for which the Society is organized and is operating. By proper provision of constitution and by-laws, either or both as may be necessary, the

county society may require of an applicant for membership that he shall have resided within the jurisdiction of the society to which he is applying, for a period of one year as a condition precedent to election to membership; or the county society may provide that an applicant for membership first may be elected to membership for a term of only one year, with the provision that such membership shall then terminate, and the member resubmit to election, without limitation as to term, by vote of the society.

A member of a component society whose license has been revoked shall be dropped from membership automatically as of the date of revocation. The Council of the State Society shall have final authority to expel a member should a component county society fail to do so after being so requested by the Council.

A physician living near a county line may hold his membership in that county most convenient for him to attend, on permission of the component society in whose jurisdiction he resides.

A member who removes his principal practice from within the territorial limits of a county medical society in which he shall hold membership, shall not be eligible to continue his membership in such society after the expiration of the calendar year in which such removal shall have occurred. Such member shall, however, be eligible to apply for membership anew or by transfer to the society in whose jurisdiction his principal practice shall have been removed.

By proper provision of Constitution and By-laws, either or both as may be necessary, a county society may admit to membership those in training as hospital residents or as research fellows who are licensed to practice medicine and surgery in the state of Wisconsin, upon the payment of dues not to exceed $5 annually, of which at least $3 shall be remitted to the State Society, provided that any applicant so elected shall not be permitted such membership beyond a period of three years from the date of such election, and shall not be included as a "fully paid" member as that term is used in Section 2 of Chapter III.

SEC. 4. Any physician who may feel aggrieved by the action of the society of his county in suspending or expelling him shall have the right to appeal to the Council, whose decision shall be final. A county society shall at all times be permitted to appeal or refer questions involving membership to the Council of the State Society for final determination. The period of time within which appeal to the Council may be taken shall be limited to six months following the date of decision by the constituted authority of a component county medical society.

SEC. 5. In hearing appeals the Council may admit oral or written evidence as in its judgment will most fairly present the facts, but in the case of every appeal both as a board and as individuals, the councilors shall, preceding all such hearings, make efforts at conciliation and compromise.

SEC. 6. When a member in good standing in a component county society moves to another county in this State, he shall be given a written certificate of these facts by the secretary of his society, without cost, for transmission to the secretary of the society in the county to which he moves. Pending his acceptance or rejection by the society in the county to which he removes, such member shall be considered to be in good standing in the county society from which he was certified and in the State Society to the end of the period (respectively) for which his dues have been paid.

SEC. 7. Each county society shall have general direction of the affairs of the profession in the county, and its influence shall be constantly exerted for bettering the scientific, moral and material condition of every physician in the county. Systematic efforts shall be made by each member, and by the society as a whole, to increase the membership until it includes every eligible physician in the county.

SEC. 8. At some meeting in advance of the annual session of this Society, each component county society shall elect one or more delegates and an equal number of individual alternates therefor to represent it in the House of Delegates of this Society, in accordance with Chapter III, Section 2, of these By-Laws. The secretary of each county society shall send a list of such delegates and alternates to the secretary of this Society at least thirty days before the annual session. Representation in the House of Delegates shall be contingent on compliance with the foregoing provisions.

SEC. 9. The secretary of each county society shall keep a roster of its members, and, if practicable, a list of nonaffiliated physicians, in which shall be shown the full name, address, college and date of graduation, date of license to practice in this State, and such other information as may be deemed necessary by Council. He shall send a copy of the program of each county meeting to his district councilor and to the secretary.

SEC. 10. Each county society shall appoint or elect one or more of its members as a member of an auxiliary Committee on Public Policy, and the county society secretary shall send his name and address at once to the secretary of this Society. The Committee on Public Policy of this Society shall formulate the duties of this auxiliary committee and supply each member with a copy. The auxiliary committee-men shall be accountable to their county societies and to the Council for prompt response to and continued cooperation with the Committee on Public Policy of this Society.

CHAPTER XII

SCIENTIFIC SECTIONS

SECTION 1. The House of Delegates shall, from time to time, establish such scientific sections within the Society as it may determine and shall have the power to combine, enlarge, or discontinue any or all of such sections so established.

SEC. 2. Such sections so established shall be based upon those divisions of medicine in which the various members possess a special interest, but qualifications for membership in any section may be prescribed by the members of such section, subject only to approval of the Council, except that scientific meetings of the section shall be open to all members in good standing of the State Medical Society.

SEC. 3. The officers of any such section shall be those prescribed by the members thereof. The terms of such officers shall be for the term of one year, but any officer may be reelected.

SEC. 4. The officers of any such section shall constitute the executive committee thereof, and a majority of the executive committee must vote with the majority of the members in order for any action of the section to be effective. The executive committee shall have the power to appoint such committees within a section as it deems necessary from time to time.

SEC. 5. No section shall have the power to bind the Society by any resolution or other action, or to publicize the same, unless the same shall first be approved by the House of Delegates, or by a majority of the members of the Council when the House of Delegates is not in session. No resolution adopted by any section shall be effective until likewise so approved.

SEC. 6. Each section so established shall have the privilege of electing a delegate and alternate to the House of Delegates.

CHAPTER XIII

SECTION 1. These By-Laws may be amended at any annual session by a majority vote of the delegates present at that session, if the proposed amendment has been properly submitted to the House of Delegates and has laid on the table for one day.

SEC. 2. Upon the adoption of this Constitution and these By-Laws, all previous Constitutions and By-Laws are thereby repealed.

YOUR DEAD LINES

Below are some of the "musts" of a practicing physician:

Taxes; Annual Narcotics Registration.

1. File your Wisconsin and federal income tax returns as early in 1943 as possible, *but not later than March 15.*
2. File a Social Security form quarterly just as in past years. Not later than January 31, 1943, you must file the return for the quarter ending December 31, 1942, and pay the employment tax due for that quarter.
3. Your first Victory Tax return will be due on or before April 30, 1943, together with tax withheld from the income of your subject employees. This will cover a period from January 1 through March 31, 1943.
4. Register as required by the federal narcotics law, and pay the annual tax *before* July 1, 1943. You are subject to penalties for overlooking either the registration or the tax.

Change of Residence:

1. If you are registered under the Selective Service Act, notify your local draft board of changes of residence or temporary absences.
2. Notify the collector of internal revenue to insure the legality of your narcotics license. Penalties are imposed for failure to do this.
3. If you take up residence in another county, record your license with the county clerk so that no question will arise as in the collection of your fees.

Remember to:

1. Make prompt report to the State Board of Health of cancer cases, communicable diseases and others as described in the article on page 127.
2. File a certificate for all births attended by you within five days of the event. Otherwise your medical fees are unlawful. Sec. 69.26, statutes.
3. Register with the county judge if you desire reference work on commitment proceedings for persons allegedly insane, epileptic, inebriate, mentally deficient, and drug addicts. Registration is limited to physicians who have practiced for two years, or have had one year's experience in a hospital for the insane. Sec. 51.01 (2), statutes.
4. Notify the next of kin or a person who may be chargeable with the funeral expenses before you send, or cause to be sent, the corpse of any deceased person to a funeral director, undertaker, mortician or embalmer. The penalty is severe for failure to do so. Secs. 156.14; 156.15 (1), statutes.

Principles of Medical Ethics of the American Medical Association

CHAPTER I

IN GENERAL

THE PHYSICIAN'S RESPONSIBILITY

SECTION 1.—A profession has for its prime object the service it can render to humanity; reward or financial gain should be a subordinate consideration. The practice of medicine is a profession. In choosing this profession an individual assumes an obligation to conduct himself in accord with its ideals.

GROUPS AND CLINICS

SEC. 2.—The ethical principles actuating and governing a group or clinic are exactly the same as those applicable to the individual. As a group or clinic is composed of individual doctors each of whom whether employer, employee or partner, is subject to the principles of ethics herein elaborated, the uniting into a business or professional organization does not relieve them either individually or as a group from the obligation they assume when entering the profession.

CHAPTER II

THE DUTIES OF PHYSICIANS TO THEIR PATIENTS

PATIENCE, DELICACY AND SECRECY

SECTION 1.—Patience and delicacy should characterize all the acts of a physician. The confidences concerning individual or domestic life entrusted by a patient to a physician and the defects of disposition or flaws of character observed in patients during medical attendance should be held as a trust and should never be revealed except when imperatively required by the laws of the state. There are occasions, however, when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected, because the physician has knowledge, obtained through the confidences entrusted to him as a physician, of a communicable disease to which the healthy individual is about to be exposed. In such a case, the physician should act as he would desire another to act toward one of his own family under like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.

PROGNOSIS

SEC. 2.—A physician should give timely notice of dangerous manifestations of the disease to the friends of the patient. He should neither exaggerate nor minimize the gravity of the patient's condition. He should assure himself that the patient or his friends have such knowledge of the patient's condition as will serve the best interests of the patient and the family.

PATIENTS MUST NOT BE NEGLECTED

SEC. 3.—A physician is free to choose whom he will serve. He should, however, always respond to any request for his assistance in an emergency or whenever temperate public opinion expects the service. Once having undertaken a case, a physician should not abandon or neglect the patient because the disease is deemed incurable; nor should he withdraw from the case for any reason until a sufficient notice of a desire to be released has been given the patient or his friends to make it possible for them to secure another medical attendant.

CHAPTER III

THE DUTIES OF PHYSICIANS TO EACH OTHER AND TO THE PROFESSION AT LARGE

ARTICLE I.—DUTIES TO THE PROFESSION

UPHOLD HONOR OF PROFESSION

SECTION 1.—The obligation assumed on entering the profession requires the physician to comport himself as a gentleman and demands that he use every honorable means to uphold the dignity and honor of his vocation, to exalt its standards and to extend its sphere of usefulness. A physician should not base his practice on an exclusive dogma or sectarian system, for "sects are implacable despots; to accept their thraldom is to take away all liberty from one's action and thought." (Nicon, father of Galen.)

MEDICAL SOCIETIES

SEC. 2.—In order that the dignity and honor of the medical profession may be upheld, its standards exalted, its sphere of usefulness extended, and the advancement of medical science promoted, a physician should associate himself with medical societies and contribute his time, energy and means in order that these societies may represent the ideals of the profession.

DEPORTMENT

SEC. 3.—A physician should be "an upright man, instructed in the art of healing." Consequently, he must keep himself pure in character and conform to

a high standard of morals, and must be diligent and conscientious in his studies. "He should also be modest, sober, patient, prompt to do his whole duty without anxiety; pious without going so far as superstition, conducting himself with propriety in his profession and in all the actions of his life." (Hippocrates.)

ADVERTISING

SEC. 4.—Solicitation of patients by physicians as individuals, or collectively in groups by whatsoever name these be called, or by institutions or organizations, whether by circulars or advertisements, or by personal communications, is unprofessional. This does not prohibit ethical institutions from a legitimate advertisement of location, physical surroundings and special class—if any—of patients accommodated. It is equally unprofessional to procure patients by indirection through solicitors or agents of any kind, or by indirect advertisement, or by furnishing or inspiring newspaper or magazine comments concerning cases in which the physician has been or is concerned. All other like self-laudations defy the traditions and lower the tone of any profession and so are intolerable. The most worthy and effective advertisement possible, even for a young physician, and especially with his brother physicians, is the establishment of a well-merited reputation for professional ability and fidelity. This cannot be forced, but must be the outcome of character and conduct. The publication or circulation of ordinary simple business cards, being a matter of personal taste or local custom, and sometimes of convenience, is not *per se* improper. As implied, it is unprofessional to disregard local customs and offend recognized ideals in publishing or circulating such cards.

It is unprofessional to promise radical cures; to boast of cures and secret methods of treatment or remedies; to exhibit certificates of skill or of success in the treatment of diseases; or to employ any methods to gain the attention of the public for the purpose of obtaining patients.

PATENTS AND PERQUISITES

SEC. 5.—It is unprofessional to receive remuneration from patents or copyrights on surgical instruments, appliances, medicines, foods, methods or procedures. It is equally unprofessional by ownership or control of patents or copyrights either to retard or to inhibit research or to restrict the benefit to patients or to the public to be derived therefrom. It is unprofessional to accept rebates on prescriptions or appliances, or perquisites from attendants who aid in the care of patients.

MEDICAL LAWS—SECRET REMEDIES

SEC. 6.—It is unprofessional for a physician to assist unqualified persons to evade legal restrictions governing the practice of medicine; it is equally unethical to prescribe or dispense secret medicines or other secret remedial agents, or manufacture or promote their use in any way.

SAFEGUARDING THE PROFESSION

SEC. 7.—Physicians should expose without fear or favor, before the proper medical or legal tribunals, corrupt or dishonest conduct of members of the profession. All questions affecting the professional reputation or standing of a member or members of the medical profession should be considered only before proper medical tribunals in executive sessions or by special or duly appointed committees on ethical relations. Every physician should aid in safeguarding the profession against the admission to its ranks of those who are unfit or unqualified because deficient either in moral character or education.

ARTICLE II.—PROFESSIONAL SERVICES OF PHYSICIANS TO EACH OTHER

PHYSICIANS DEPENDENT ON EACH OTHER

SECTION 1.—Experience teaches that it is unwise for a physician to treat members of his own family or himself. Consequently, a physician should always cheerfully and gratuitously respond with his professional services to the call of any physician practicing in his vicinity, or of the immediate family dependents of physicians.

COMPENSATION FOR EXPENSES

SEC. 2.—When a physician from a distance is called on to advise another physician or one of his family dependents, and the physician to whom the service is rendered is in easy financial circumstances, a compensation that will at least meet the traveling expenses of the visiting physician should be proffered. When such a service requires an absence from the accustomed field of professional work of the visitor that might reasonably be expected to entail a pecuniary loss, such loss should, in part at least, be provided for in the compensation offered.

ONE PHYSICIAN TO TAKE CHARGE

SEC. 3.—When a physician or a member of his dependent family is seriously ill, he or his family should select a physician from among his neighing colleagues to take charge of the case. Other physicians may be associated in the care of the patient as consultants.

ARTICLE III.—DUTIES OF PHYSICIAN IN CONSULTATIONS

CONSULTATIONS SHOULD BE ENCOURAGED

SECTION 1.—In serious illness, especially in doubtful or difficult conditions, the physician should request consultations.

CONSULTATION FOR PATIENT'S BENEFIT

SEC. 2.—In every consultation, the benefit to be derived by the patient is of first importance. All the physicians interested in the case should be frank and candid with the patient and his family. There never is occasion for insincerity, rivalry or envy and these should never be permitted between consultants.

PUNCTUALITY

SEC. 3.—It is the duty of a physician, particularly in the instance of a consultation, to be punctual in attendance. When, however, the consultant or the physician in charge is unavoidably delayed, the one who first arrives should wait for the other for a reasonable time, after which the consultation should be considered postponed. When the consultant has come from a distance, or when for any reason it will be difficult to meet the physician in charge at another time, or if the case is urgent, or if it be the desire of the patient, he may examine the patient and mail his written opinion, or see that it is delivered under seal, to the physician in charge. Under these conditions, the consultant's conduct must be especially tactful; he must remember that he is framing an opinion without the aid of the physician who has observed the course of the disease.

PATIENT REFERRED TO SPECIALIST

SEC. 4.—When a patient is sent to one specially skilled in the care of the condition from which he is thought to be suffering, and for any reason it is impracticable for the physician in charge of the case to accompany the patient, the physician in charge should send to the consultant by mail, or in the care of the patient under seal, a history of the case, together with the physician's opinion and an outline of the treatment, or so much of this as may possibly be of service to the consultant; and as soon as possible after the case has been seen and studied, the consultant should address the physician in charge and advise him of the results of the consultant's investigation of the case. Both these opinions are confidential and must be so regarded by the consultant and by the physician in charge.

DISCUSSIONS IN CONSULTATION

SEC. 5.—After the physicians called in consultation have completed their investigations of the case, they should meet by themselves to discuss conditions and determine the course to be followed in the treatment of the patient. No statement or discussion of the case should take place before the patient or friends, except in the presence of all the physicians attending or by their common consent; and no opinions or prognostications should be delivered as a result of the deliberations of the consultants, which have not been concurred in by the consultants at their conference.

ATTENDING PHYSICIAN RESPONSIBLE

SEC. 6.—The physician in attendance is in charge of the case and is responsible for the treatment of the patient. Consequently, he may prescribe for the patient at any time and is privileged to vary the mode of treatment outlined and agreed on at a consultation whenever, in his opinion, such a change is warranted. However, at the next consultation, he should state his reasons for departing from the course decided on at the previous conference. When an emergency occurs during the absence of the attending physician, a consultant may provide for the emergency and the subsequent care of the patient until the arrival of the physician in charge, but should do no more than this without the consent of the physician in charge.

CONFLICT OF OPINION

SEC. 7.—Should the attending physician and the consultant find it impossible to agree in their view of a case another consultant should be called to the conference or the first consultant should withdraw. However, since the consultant was employed by the patient in order that his opinion might be obtained, he should be permitted to state the result of his study of the case to the patient, or his next friend in the presence of the physician in charge.

CONSULTANT AND ATTENDANT

SEC. 8.—When a physician has attended a case as a consultant, he should not become the attendant of the patient during that illness except with the consent of the physician who was in charge at the time of the consultation.

ARTICLE IV.—DUTIES OF PHYSICIANS IN CASES OF INTERFERENCE

MISUNDERSTANDINGS TO BE AVOIDED

SECTION 1.—The physician, in his intercourse with a patient under the care of another physician, should observe the strictest caution and reserve; should give no disingenuous hints relative to the nature and treatment of the patient's disorder; nor should the course of conduct of the physician, directly or indirectly, tend to diminish the trust reposed in the attending physician. In embarrassing situations, or wherever there may seem to be a possibility of misunderstanding with a colleague, the physician should always seek a personal interview with his fellow.

SOCIAL CALLS ON PATIENT OF ANOTHER PHYSICIAN

SEC. 2.—A physician should avoid making social calls on those who are under the professional care of other physicians without the knowledge and consent of the attendant. Should such a friendly visit

be made, there should be no inquiry relative to the nature of the disease or comment upon the treatment of the case, but the conversation should be on subjects other than the physical condition of the patient.

SERVICES TO PATIENT OF ANOTHER PHYSICIAN

SEC. 3.—A physician should never take charge of or prescribe for a patient who is under the care of another physician, except in an emergency, until after the other physician has relinquished the case or has been properly dismissed.

CRITICISM TO BE AVOIDED

SEC. 4.—When a physician does succeed another physician in the charge of a case, he should not make comments on or insinuations regarding the practice of the one who preceded him. Such comments or insinuations tend to lower the esteem of the patient for the medical profession and so react against the critic.

EMERGENCY CASES

SEC. 5.—When a physician is called in an emergency and finds that he has been sent for because the family attendant is not at hand, or when a physician is asked to see another physician's patient because of an aggravation of the disease, he should provide only for the patient's immediate need and should withdraw from the case on the arrival of the family physician after he has reported the condition found and the treatment administered.

WHEN SEVERAL PHYSICIANS ARE SUMMONED

SEC. 6.—When several physicians have been summoned in a case of sudden illness or of accident the first to arrive should be considered the physician in charge. However, as soon as the exigencies of the case permit, or on the arrival of the acknowledged family attendant or the physician the patient desires to serve him, the first physician should withdraw in favor of the chosen attendant; should the patient or his family wish some one other than the physician known to be the family physician to take charge of the case the patient should advise the family physician of his desire. When, because of sudden illness or accident, a patient is taken to a hospital, the patient should be returned to the care of his known family physician as soon as the condition of the patient and the circumstances of the case warrant this transfer.

A COLLEAGUE'S PATIENT

SEC. 7.—When a physician is requested by a colleague to care for a patient during his temporary absence, or when, because of an emergency, he is asked to see a patient of a colleague, the physician should treat the patient in the same manner and with the same delicacy as he would have one of his own patients cared for under similar circumstances. The patient should be returned to the care of the attending physician as soon as possible.

RELINQUISHING PATIENT TO REGULAR ATTENDANT

SEC. 8.—When a physician is called to the patient of another physician during the enforced absence of that physician, the patient should be relinquished on the return of the latter.

SUBSTITUTING IN OBSTETRIC WORK

SEC. 9.—When a physician attends a woman in labor in the absence of another who has been engaged to attend, such physician should resign the patient to the one first engaged, upon his arrival; the physician is entitled to compensation for the professional services he may have rendered.

ARTICLE V.—DIFFERENCES BETWEEN PHYSICIANS

ARBITRATION

SECTION 1.—Whenever there arises between physicians a grave difference of opinion which cannot be promptly adjusted, the dispute should be referred for arbitration to a committee of impartial physicians, preferably the Board of Censors of a component county society of the American Medical Association.

ARTICLE VI.—COMPENSATION

LIMITS OF GRATUITOUS SERVICE

SECTION 1.—The poverty of a patient and the mutual professional obligation of physicians should command the gratuitous services of a physician. But endowed institutions and organizations for mutual benefit, or for accident, sickness and life insurance, or for analogous purposes, have no claim upon physicians for unremunerated services.

CONDITIONS OF MEDICAL PRACTICE

SEC. 2.—It is unprofessional for a physician to dispose of his services under conditions that make it impossible to render adequate service to his patient or which interfere with reasonable competition among the physicians of a community. To do this is detrimental to the public and to the individual physician, and lowers the dignity of the profession.

CONTRACT PRACTICE

SEC. 3.—By the term "contract practice" as applied to medicine is meant the carrying out of an agreement between a physician or a group of physicians, as principals or agents, and a corporation, or-

ganization, political subdivision or individual, to furnish partial or full medical services to a group or class of individuals on the basis of a fee schedule, or for a salary or a fixed rate per capita.

Contract practice *per se* is not unethical. However, certain features or conditions if present make a contract unethical, among which are: (1) When there is solicitation of patients, directly or indirectly. (2) When there is underbidding to secure the contract. (3) When the compensation is inadequate to assure good medical service. (4) When there is interference with reasonable competition in a community. (5) When free choice of a physician is prevented. (6) When the conditions of employment make it impossible to render adequate service to the patients. (7) When the contract because of any of its provisions or practical results is contrary to sound public policy. The phrase "free choice of physician," as applied to contract practice, is defined to mean that degree of freedom in choosing a physician which can be exercised under usual conditions of employment between patient and physician when no third party has a valid interest or intervenes. The interjection of a third party who has a valid interest or who intervenes does not *per se* cause a contract to be unethical. A "valid interest" is one where, by law or necessity, a third party is legally responsible either for cost of care or for indemnity. "Intervention" is the voluntary assumption of partial or full financial responsibility for medical care. Intervention shall not proscribe endeavor by component or constituent medical societies to maintain high quality of service rendered by members serving under approved sickness service agreements between such societies and governmental boards or bureaus and approved by the respective societies.

Each contract should be considered on its own merits and in the light of surrounding conditions. Judgment should not be obscured by immediate, temporary or local results. The decision as to its ethical or unethical nature must be based on the ultimate effect for good or ill on the people as a whole.

COMMISSIONS

SEC. 4.—When a patient is referred by one physician to another for consultation or for treatment, whether the physician in charge accompanies the patient or not, it is unethical to give or to receive a commission by whatever term it may be called or under any guise or pretext whatsoever.

DIRECT PROFIT TO LAY GROUPS

SEC. 5.—It is unprofessional for a physician to dispose of his professional attainments or services to any lay body, organization, group or individual, by whatever name called, or however organized, under terms or conditions which permit a direct profit from the fees, salary, or compensation received to accrue to the lay body or individual employing him. Such a procedure is beneath the dignity of professional practice, is unfair competition with the profession at large, is harmful alike to the profession of medicine and the welfare of the people, and is against sound public policy.

CHAPTER IV

THE DUTIES OF THE PROFESSION TO THE PUBLIC

PHYSICIANS AS CITIZENS

SECTION 1.—Physicians, as good citizens and because their professional training specially qualifies them to render this service, should give advice concerning the public health of the community. They should bear their full part in enforcing its laws and sustaining the institutions that advance the interests of humanity. They should cooperate especially with the proper authorities in the administration of sanitary laws and regulations. They should be ready to counsel the public on subjects relating to sanitary police, public hygiene and legal medicine.

PUBLIC HEALTH

SEC. 2.—Physicians, especially those engaged in public health work, should enlighten the public regarding quarantine regulations; on the location, arrangement and dietaries of hospitals, asylums, schools, prisons and similar institutions; and concerning measures for the prevention of epidemic and contagious diseases. When an epidemic prevails, a physician must continue his labors for the alleviation of suffering people, without regard to the risk to his own health or life or to financial return. At all times, it is the duty of the physician to notify the properly constituted public health authorities of every case of communicable disease under his care, in accordance with the laws, rules and regulations of the health authorities of the locality in which the patient is.

PUBLIC WARNED

SEC. 3—Physicians should warn the public against the devices practiced and the false pretentions made by charlatans which may cause injury to health and loss of life.

PHARMACISTS

SEC. 4. — By legitimate patronage, physicians should recognize and promote the profession of pharmacy; but any pharmacist, unless he be qualified as a physician, who assumes to prescribe for the sick, should be denied such countenance and support. Moreover, whenever a druggist or pharmacist dispenses deteriorated or adulterated drugs, or substi-

tutes one remedy for another designated in a prescription, he thereby forfeits all claims to the favorable consideration of the public and physicians.

CONCLUSION

While the foregoing statements express in a general way the duty of the physician to his patients, to other members of the profession and to the profession at large, as well as of the profession to the public, it is not to be supposed that they cover the whole field of medical ethics, or that the physician is not under many duties and obligations besides these herein set forth. In a word, it is incumbent on the physician that under all conditions, his bearing toward patients, the public and fellow practitioners should be characterized by a gentlemanly deportment and that he constantly should behave toward others as he desires them to deal with him. Finally, these principles are primarily for the good of the public, and their enforcement should be conducted in such a manner as shall deserve and receive the endorsement of the community.

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Gundersen, Gunnar
Gundersen, S. B
Gundersen, T. E.
Harman, J. C.
Heraty, J. E.
Houck, Mary Piper
Johnston, Russell
Jones, W. J.
Lueck, G. W.
McGarty, M. A.
McLoone, J. E.
Montgomery, S. A.
Moran, C. J.
Reay, G. R.
Remer, W. H.
Rosholt, J. A.
Roth, J. A.
Schneeberger, E. J.
Seedorf, E. E.
Simones, J. J.
Sivertson, M.
Skemp, A. A.
Skemp, G. E.
Smith, D. S.
Swarthout, Edyth C.
Townsend, E. H.
Walters, P. T.
Wolf, F. H.
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Bauer, W. B. A.
Lundmark, L. M.
O'Connor, W. F.
Pagel, H. F.
Smith, Woodruff

La Farge:
Gallin, F. F.
Sporleder, O.

Lake Geneva:
Brady, C. J.
Hudson, E. D.
Jeffers, Dean
MacDonald, W. H.

Lake Mills:
Eck, G. E.
Leicht, Philip
Peterson, M. G.
Schoenecker, E. A.

Lancaster:
Carey, H. W.
Fowler, J. H.
Glynn, J. D.
Godfrey, R. C.
Houghton, E. M.
Kraut, Elgie

Laona:
Carroll, G. E.
Ovitz, E. G.

Larsen:
Henrichsen, J. A.

LaValle:
Booher, J. A.

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Rose, J. F.

Little Chute:
Curtin, D. W.
Doyle, J. H.
Verbrick, W. C.

Lodi:
Groves, R. J.
Irwin, G. H.

Loganville:
Jewell, E. L.

Loyal:
Hable, A. P.

Luck:
Peterson, S. C.

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Aageson, C. W.
Allin, R. N.
Atwood, David
Bane, H. W.
Bell, P. P.
Birge, E. A.
Bleckwenn, W. J.
Bohorfoush, J. G.
Boner, A. J.
Bowman, F. F.
Brehm, P. A.
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Brindley, B. I.
Britton, D. M.
Bryan, A. W.
Burke, C. F.
Burke, Mead
Burke, Myra
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Campbell, R. E.
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Carter, H. M.
Chorlog, J. K.
Cole, L. R.
Coluccy, M. J. J.
Cooksey, R. T.
Coon, H. M.
Coontz, O. H.
Cooper, G. A.
Curreri, A. R.
Davis, F. A.
Davis, Helen P.
Davis, R. R.
Dean, F. K.
Dean, J. C.
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Dimond, W. B.
Dollard, J. E.
Domine, A. Z.
Duehr, P. A.
Ellis, I. G.
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Foster, Ruth C.
Frankenstein, N. A.
Gale, J. W.
Gallagher, J. T.
Ganser, W. J.
Gearhart, R. S.
Geist, F. D.
Gonce, J. E., Jr.
Gordon, E. S.
Grab, J. A. (Selective Service)
Greeley, H. P.
Greene, H. L.
Greiber, M. F.
Grimstad, Frances H.
Grumke, E. H.
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Harper, C. A.
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Hellebrandt, F. A.
Hill, N. A.
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Hunt, T. D.
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Jackson, R. H.
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Johnson, A. C.
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Krehl, W. H.
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Stehr, A. C.
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Wirka, H. W.

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Portman, R. J.
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Rees, T. H.
Scherping, W. H.
Schneck, Nathan
Sobush, L. D.
Steckbauer, J. W.
Strong, R. G.
Stueck, A. F.
Teltgen, Arthur
Teitgen, T. A.
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Wall, C. E.
Yost, R. G.

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Kampine, C. E.

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May, J. H.

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Boren, C. H.
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Duer, G. R.
Jorgenson, H. L.
May, J. V.
Nadeau, A. T.
Pinegar, K. G.
Schroeder, H. F.
Shaw, R. W.
Zeratsky, J. D.

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Van Schaick, R. E.

Markesan:
Cupery, D. P.
Sinaiko, E. S.

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Copps, L. A.
Doege, K. H.
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Epstein, S. E.
Hipke, Wm.
Mason, R. W.
McCormick, G. L.
McGinn, E. J.
Millard, A. L.
Potter, R. P.
Talbot, J. R.
Vedder, C. A.
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Wickham, J. M.
Wink, R. H.
Wyatt, T. E.

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Partridge, O. F.

Mauston:
Hess, J. S.

Mayville:
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Parish, G. A.

Mazomanie:
Schultz, I.

Medford:
Elvis, E. B.
Norton, D. M.
Nystrum, L. E.
Nystrum, R. C.

Mellen:
Lockhart, C. W.

Melrose:
Lavine, I. H.

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Forkin, G. E.
Hildebrand, W. B.
Jensen, F. G.
Jensen, R. A.
O'Brien, P. T.
Pratt, G. N., Jr.
Shemanski, L. S.

Mendota:
Green, M. K.
Sauthoff, August
Urben, W. J.

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Burkhardt, E. W.
Domann, W. G.
Hoyt, G. E.
Schloemer, A. J.

Menomonie:
Buckley, C. H.
Butler, F. E.
Grannis, I. V.
Halgren, J. A.
Long, D. T.
Lumsden, Wm.
McMahon, A. E.
Quilling, P. A.
Steves, B. J.
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Kremers, A.

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Austria, W. F.
Bayer, L. J.
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Kelley, F. H.
Lane, F. C.
Morris, K. A.
Ravn, Bjarne
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Stricker, M. F.

Milltown:
Bergstrom, L. B.
Maser, J. F.
Rechlitz, E. T.

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Crosley, G. E.
Davis, M. D.

Milton Junction:
Vogel, T. L.

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Adamkiewicz, J. J.
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Allen, L. L.
Ansfield, D. J.
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Appleby, K. B.
Armbruster, J. L.
Aszman, P. E.
Augur, Alexander
Ausman, D. C.
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Aylward, T. J.
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Bach, E. C.
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Baugh, C. W.
Baum, E. L.
Baumann, A. J.
Baumgart, C. H.
Beck, R. W.
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Beckman, Harry
Beffel, J. M., Jr.
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Benton, R. W.
Bentzien, E. W.
Bercey, J. E.
Bergen, R. D.
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Beutler, Alfred
Bickler, E. P.
Biller, J. H.
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Birk, B. J.
Blair, J. F.
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Blankstein, S. S.
Blount, W. P.
Blumenthal, R. W.
Bolger, J. V.
Borman, M. C.
Bornstein, Max
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Bourne, N. W.
Boxer, L. M.
Brachman, Louis
Brizard, J. L.
Broderick, C. F.
Brook, J. J.
Brown, G. V. I.
Bruins, Dirk
Brukhardt, H. R.
Brunkhorst, R. O.
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Brzezinski, E. A.
Budny, C. L.
Burbach, T. H.
Burgardt, G. F.
Burnett, C. H.
Busby, W. W.
Byrnes, M. B.
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Callan, P. L.
Cannon, H. J.
Carey, E. J.
Carhart, G. A.
Carl, E. E.
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Carson, W. J.
Cash, I. I.
Casper, W. T.
Ceci, G. E.
Champney, R. D.
Charles, J. D.
Churchill, B. P.
Clasen, E. A.
Cleary, E. M.
Cleveland, David
Coffey, C. J.
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Colgan, J. J.
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Collopy, P. J.
Conway, J. P.
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Cox, J. A.
Craite, E. J.
Cron, R. S.
Crottier, C. J.
Cunningham, H. A.
Currer, P. M.
Curtin, J. G.
Cushing, Eleänore
Darling, F. E.
Darling, F. E., Jr.
Darling, S. J.
Davidoff, I. J.
Decker, H. G.
Demeter, N. D.
de Neveu, A. V.
Derse, F. R.
Devitt, J. S.
Diamond, C. O.
Dieterle, J. O.
Differt, C. C.
Dishmaker, M. C.
Doerr, August
Donath, L. H.
Drew, F. E.
Drexel, Arnold
Dricken, H. N.
Drozewski, M. F.
Dundon, J. R.
Dunker, G. O.
Dunn, C. F.
Dunst, C. G.
Durner, U. J.
Dvorak, H. J.
Eberbach, C. W.
Echols, C. M.
Egan, W. J.
Eichenberger, C. R.
Eisele, P. L.
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Elsenberg, L. A.
Eisenberg, P. J.
Elconin, D. V.
End, E. M.
Enright, J. A.
Enzer, Norbert
Epperson, P. S.
Epstein, Ely
Erdlitz, F. J.
Ernst, G. R.
Evans, C. A.
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Fabric, B. L.
Falk, V. S.
Farrell, H. J.
Fechter, F. J.
Federspiel, M. N.
Feiman, L. H.
Fein, N. N.
Feld, S. M.
Feldt, R. H.
Fellman, G. H.
Fernan-Nunez, M.
Fetherston, J. P.
Fidler, Charles
Fisher, L. M.
Fitzgerald, G. F.
Fitzgerald, R. E.
Fitzgibbon, Wm.
Foerster, H. R.
Foerster, O. H.
Foley, L. J.
Fons, J. W.
Ford, W. B.
Fortier, C. A. H.
Fox, G. W.
Fox, M. J.
Fox, M. S.
Frackelton, W. H.
Franklin, E.
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Frawley, D. D.
Frey, P. G.
Friedman, G. H.

Frisch, R. A.
Froelich, J. A.
Fromm, A. H.
Gabor, M. E.
Galasinski, R. E.
Garens, R. W.
Garland, J. G.
Garvey, J. L.
Gaunt, J. J.
Gebhard, U. E.
Geiger, Sara G.
Gendlin, N. A.
Gertenbach, E. O.
Gilchrist, R. T.
Gilmer, L. T.
Gingrass, R. P.
Gilsch, W. P.
Goldberg, Nathan
Goodman, J. S.
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Goodsitt, A. H.
Gorder, A. C.
Gordon, J. S.
Gramling, E. H.
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Gray, A. W.
Greenberg, A. I.
Greenthal, R. M.
Griffith, J. C.
Grill, John
Grimm, J. J.
Grob, A. R. F.
Grosskopf, E. C.
Grossmann, E. E.
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Grotjan, W. F.
Grove, W. E.
Gudex, V. A.
Guepe, J. W.
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Gumerman, G. J.
Gute, E. B.
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Habeck, E. A. W.
Haberland, J. E.
Haessler, B. T.
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Hake, C. B.
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Halser, J. G.
Hankwitz, A. W.
Hanley, W. J.
Hansen, H. T.
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Hansher, Ervin
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Harder, Henry
Hardgrove, Maurice
Hardy, C. F.
Hargarten, L. J.
Harper, C. W.
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Haug, J. F.
Haushalter, H. P.
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Heidner, F. C.
Helfetz, E. C.
Hell, J. V.
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Huth, E. P.
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Irwin, Robert
Jackson, Edward
Jacobson, E. B.
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Jermain, W. M.
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Lee, P. A.
Leitch, G. W.
Levine, Abram
Lewis, Marian
Lieberman, Benj.
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Light, George
Lillie, O. R.
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Lotz, Oscar
Loughlin, D. M.
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Miner, H. B.
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Owen, J. D.
Ozonoff, J. B.
Pallasch, F. J.
Panetti, E. J.
Panetti, H. E.
Park, C. F.
Patek, A. J.
Paulbeck, T. M.
Peelen, A. W.
Pegram, J. W.
Perlson, P. H.
Peterman, M. G.
Peters, B. J.
Peters, L. M.
Peyton, L. T.
Pfeffer, E. N.
Piaskoski, R. G.
Pink, J. J.
Plahner, Samuel
Pleyte, A. A.
Pohle, H. W.
Polacheck, W. S.
Pollack, S. K.
Popp, Albert
Powers, H. W.
Prestl, A. A.
Prudowsky, H. H.
Pugh, G. J.
Purtell, P. J.
Purtell, R. F.
Quick, A. J.
Quick, E. W.
Rabin, Allen
Ragan, W. F.
Raine, Forrester
Randolph, T. G.
Rank, R. T.
Rastetter, J. W.
Raymond, A. J.
Reifenrath, I. B.
Reinke, C. C.
Rettig, E. H.
Rettig, Frank
Reuter, M. J.
Rheineck, A. F.
Rice, E. L.
Rice, E. M.
Rich, G. J.
Riehl, F. W.
Rife, C. S.
Rikkers, D. F.
Ringo, H. F.
Roberts, D. W.
Robinson, H. P.
Roby, H. S.
Rock, J. N.
Roethke, R. W.
Rogers, A. F.
Rogers, E. H.
Rogers, M. F.
Rolfs, T. H.
Rosenbaum, M. K.
Rosenberger, A. I.
Rosenthal, S.
Ross, F. A.
Rowan, J. P.
Ruppenthal, A. J.
Ruschhaupt, L. F.
Russell, R. J. M.
Ryan, P. W.
Ryan, W. A.
Sadoff, H. B.
Saketos, T. P.
Salinko, S. S.
Sander, O. A.
Sanfelippo, A. J.
Sargent, J. C.
Sass, L. C.
Savage, G. F.
Savage, G. T.
Schacht, W. J.
Schade, R. E.
Schaefer, A. A.
Schelbie, E. J.
Schelble, J. P.
Schlaepfer, K.
Schlomovitz, B. H.
Schlomovitz, E. H.
Schlossmann, B.
Schlueter, F. E.
Schlueter, U. A.
Schmidt, A. C.
Schmidt, E. C.
Schmidt, H. G.
Schmidt, J. A.
Schmit, Felix
Schmit, Louis
Schnapp, A. C.
Schneeberger, L. J.
Schneider, C. C.
Schneider, C. R.
Schneider, C. S.
Schodron, R. C.
Schoen, C. M.
Schoenkerman, B. B.
Scholter, E. A. W.
Scholz, G. M.
Schoofs, O. P.
Schowalter, R. P.
Schramel, A. J.
Schroeder, H. T.
Schroeder, J. C.
Schubert, F. J.
Schuler, F. X.
Schulz, Irwin
Schumacher, H. S.
Schumm, H. C.
Schutte, A. G.
Schwade, E. D.

Schwartz, A. B.
Schwartz, S. F.
Schweiger, L. R.
Schweitzer, G. J.
Schweitzer, W. A.
Seeger, S. J.
Seegers, F. W.
Seelman, A. G.
Seelman, J. J.
Selle, F. S.
Senn, Ulrich
Shaiken, Joseph
Shaner, G. O.
Shapiro, A. M.
Sherwood, M. W.
Shimpa, J. F.
Shutkin, Michael
Shutter, H. W.
Siekert, H. P.
Silbar, S. J.
Sivyer, A. W.
Slutzky, Nathan
Smith, J. W.
Smith, L. D.
Smuckler, R. H.
Spilberg, S. B.
Spitz, M. M.
Sponner, Robert
Spooner, A. D.
Sproule, R. P.
Squier, T. L.
Stamm, L. P.
Stanley, W. S.
Stark, R. M.
Steele, J. D., Jr.
Stefanez, J. S.
Steiner, C. M.
Steinkopff, E. K.
Stern, Louis
Stetner, W. L.
Stockinger, R. E.
Stratton, F. A.
Straus, G. D.
Studley, W. H.
Sullivan, J. M.
Sure, J. H.
Sutter, E. H.
Sverdlin, A. A.
Sweemer, W. M.
Sweet, S. J.
Szymarek, J. E.
Tabachnick, H.
Tallmadge, G. K.
Tashkin, E. H.
Taube, E. L.
Taylor, J. G.
Tegtmeyer, G. F.
Teschan, R. A.
Tessier, A. F.
Tharinger, E. L.
Thill, G. E.
Thompson, E. X.
Thompson, R. D.
Thorstensen, A. H.
Thranow, J. A.
Tillson, E. M.
Tolan, T. L.
Tomkiewicz, N. O.
Torcivia, S. S.
Treskow, F. G.
Troxel, J. C.
Truitt, J. W.
Tufts, Millard
Turner, V. C.
Turney, C. F.
Uhley, M. H.
Unger, A. A.
Urdan, B. E.
Usow, J. M.
Uszler, L. B.
Van de Erve, W.
Van Hecke, L. J.
Vander Linde, L. A.
Verch, L. H.
Verdone, A. J.
Wagner, P. C.
Waldman, I. J.
Walker, L. J.
Wallner, Adolf
Wallschlaeger, G. G.
Walton, W. B.
Warner, R. C.
Warschauer, B.
Washburn, R. G.
Watry, T. D.
Weber, A. J.
Wegmann, G. H.
Wegmann, N. J.
Weingart, W. F.
Weinshel, L. R.
Weisfeld, F. G.
Weisfeldt, L. A.
Weisfeldt, S. C.
Weller, R. R.
Wendt, W. P.
Wenstrand, D. E. W.
Werner, D. J.
Werner, J. J.
Westhofen, R. C.
Wetzler, S. H.
Whalen, G. E.
Wieder, L. M.
Wiese, M. E. J.
Wiesen, R. P.
Wild, J. P.
Wilets, J. B.
Wilets, J. C.
Wilkinson, E. D.
Wilske, C. A.
Winnemann, W. J.
Winter, W. G.
Wirthwein, Carlton
Witte, D. H.
Witte, W. C. F.
Wolter, S. H.
Wright, H. H.
Wyman, J. F.
Yaffe, Aaron
Yanke, A. E.
Young, A. F.
Zaun, J. J., Jr.
Zawodny, S. E.
Zillmer, Helen J.
Zimmermann, C.
Zintek, S. S.
Zivnuska, J. F.
Zmyslony, W. P.
Zubatsky, D. J.
Zuercher, J. C.
Zurheide, H. O.

Mineral Point:
Ludden, H. D.

Minocqua:
Huber, G. W.
Sprague, J. P.
Torpy, T. G.

Mishicot:
Darby, R. C.
Skwor, C. J.

Mondovi:
Gillette, F. J.
Hansen, L. B.
Johnson, B. F.
Sharp, D. S.

Monroe:
Baumle, C. E.
Bear, N. E.
Bear, W. G.
Bristow, J. H.
Creasy, L. E.
Fillbach, H. E.
Gnagi, W. B.
Gnagi, W. B., Jr.
Kindschi, L. G.
Kundert, F. W.
Moore, L. A.
Ruehlman, D. D.
Schindler, J. A.

Montello:
Inman, R. F.
McNamara, L. V.

Monticello:
Ohlsen, M. P.

Montreal:
Garry, M. W.
Pierpont, J. M.

Mosinee:
Butler, E. F.
Jackson, J. A.

Mount Calvary:
Baasen, J. M.
Miller, J. F.

Mount Horeb:
Forman, Judson
Thompson, A. S.

Mukwonago:
Voellings, W. J.

Muscoda:
Klockow, W. E.
Walsh, J. D.

Muskego:
Keim, G. J.

Neenah:
Anderson, G. R.
Baxter, H. L.
Beglinger, H. F.
Broberg, Gail
Brunckhorst, F. O.
Canavan, J. P.
Foseid, O. F.
Lowe, R. C.
Moon, R. A.
Ozanne, I. E.
Petersen, G. W.
Pitz, M. N.
Quade, R. H.
Smith, T. D.
Williamson, G. H.

Neillsville:
Frank, H. A.
Frank, J. H.
Housley, H. W.
Rosekrans, M. C
Rosekrans, Sarah D.

Nekoosa:
Backus, O. A.
Pomainville, G. J.
Pomainville, H. G.

Neopit:
Richardson, R. C.

Newburg:
Weber, H. F.

New Franken:
Looze, J. A.

New Glarus:
Francois, S. J. A.
Hicks, E. V.
McQuillin, E. D.

New Holstein:
Engel, A. C.
Krohn, H. C.

New Lisbon:
Starnes, Brand

New London:
Borchardt, M. A.
Dernbach, G. P.
Monsted, J. W.
Pfeifer, F. J.
Schmallenberg, H. C.

New Richmond:
Armstrong, J. H.
Drury, E. M.
Epley, O. H.

Niagara:
McCormack, Edward

North Freedom:
Buckley, T. J.

North Lake:
Donnelly, F. J.

Norwalk:
Allen, J. S.

Oconomowoc:
Clark, O. C.
Giffin, J. S.
Hassall, J. C.
James, W. D.
Loughnan, A. J.
Love, G. R.
Morrison, D. A. R.
Nammacher, T. H.
Stemper, I. T.
Theobald, P. B.
Wilkinson, D. C.
Wilkinson, J. D.
Wilkinson, J. F.
Wilkinson, M. R.

Oconto:
Aageson, H. A.
Kwapy, C. R.
Pankow, H. W.
Slaney, A. F.
Tousignant, A. N.

Oconto Falls:
Goggins, R. J.
Krahn, G. W.
Ohswaldt, H. F.

Omro:
Schoenbechler, L. J.
Springer, V. G.

Onalaska:
Reay, G. D.

Ontario:
Devine, G. C.

Oostburg:
Hougen, E. T.

Oregon:
Johnson, E. S.
Joyner, T. H.

Orfordville:
Belting, G. W.
McNair, E. R.

Osceola:
Jeronimus, H. J., Jr.
Simenstad, L. O.

Oshkosh:
Beatty, S. R.
Bitter, R. H.
Clark, Burton
Clark, W. E.
Connell, F. G.
Cummings, E. F.
Danforth, Q. H.
Donkle, M. J.
Ebert, R. O.
Fraser, J. M.
Haines, M. C.
Haubrick, H. J.
Helmes, L. O.
Hogan, J. M.
Hugo, D. G.
Kleinschmit, H. W.
Koehler, A. G.
Kronzer, J. J.
Kuhn, R. V.
Lee, H. J.
Linn, W. N.
Lockhart, J. W.
Lynch, G. V.
Mellicke, C. A.
Meli, J. V.
Mendez, A. A.
Meusel, H. H.
Owen, G. C.
Pfefferkorn, E. B.
Romberg, H. A.
Schein, J. E.
Smith, L. M.
Steele, G. A.
Steen, M. H.
Stein, J. F.
Wagner, R. F.
Wagner, W. A.
Wheeler, W. P.
Williams, E. B.
Wright, P. E.

Osseo:
Knutson, O.
Leasum, R. N.

Owen:
Dike, B. H.

Oxford:
Ingersoll, R. S.

Palmyra:
Bertolaet, E. E.

Pardeeville:
Chandler, J.
Gillette, H. E.

Park Falls:
Leahy, J. D.
Murphy, J. L.
Riley, E. A.

Pepin:
Belitz, A. E.
Bryant, G. E.

Peshtigo:
Bell, J. M.
Haasl, H. W.

Pewaukee:
Egloff, L. W.
Hoel, K. P.
Kelly, J. P.

Phelps:
Lutz, J. J.

Phillips:
Norviel, H. B.
Rens, J. L.
Van Hecke, D. S.

Pittsville:
Beyer, Hart
Glenn, E. C.

Plain:
Fowler, P. H.

Plainfield:
Ingersoll, B. P.

Platteville:
Andrew, C. H.
Cunningham, Wilson
Doeringsfeld, H. L.
Schuldt, C. M.
Soles, F. A.
Wheeler, C. H. E.

Plum City:
Anderson, O. H.

Plymouth:
Brickbauer, A. J.
Deicher, H. F.
Dietesch, L. C.
Mueller, J. F.
Radloff, A. C.
Sieker, A. W.
Yoran, C. M.

Portage:
Batty, A. J.
Doersch, E. A.
Harkins, J. P.
Henney, C. W.
MacGregor, J. W.
Taylor, W. A.
Tierney, E. F.

Port Washington:
Barr, Arnold
Drissen, W. H.
Kauth, C. P.
Pomeroy, R. K.
Stein, C. C.

Potosi:
Kelly, Wm. J.

Pound:
Pelkey, R. B.

Poynette:
Dryer, R. B.
Focke, W. J.

Poy Sippi:
Stimpson, G. C.

Prairie du Chien:
Armstrong, C. A.
Dessloch, E. M.
Farrell, T. F.
Kane, J. J.
Kleinpell, H. H.
Lechtenberg, E. H.
Sargeant, G. M.
Satter, O. E.
Shapiro, H. L.

Prairie du Sac:
Hannan, K. D. L.
Randall, E. M.

Prentice:
MacKinnon, G. E.

Prescott:
Dill, G. M.
Laney, H. J.

Pulaski:
Gallette, L. E.
Goggins, J. R.
Shippy, V. J.

Racine:
Adamski, A. W.
Albino, J. M.
Beeson, H. B.
Boyer, H. N.
Brehm, H. G.
Brehm, H. J.
Browne, C. F.
Buckley, W. E.
Christensen, F. C.
Constantine, C. E.
Covell, K. W.
Docter, J. C.
Faber, S. J.
Fazen, L. E.
Gillett, G. N.
Gosman, J. A.
Hahn, C. K.
Hahn, P. R.
Hanson, W. C.
Hemmingsen, T. C.
Henken, J. F.
Hilker, H. C.
Hogan, J. H.
Howe, H. W.
Jamieson, R. D.
Jones, Beatrice O.
Kehl, K. C.
Keland, H. B.
Kline, C. L.
Konnak, Wm. F.
Kreul, R. W.
Kurten, R. M.
Lifschutz, L. M.
Lindner, A. M.
Marek, F. B.
Miller, H. C.
Nelson, A. L.
Peterson, R. O.
Pfeffer, T. J.
Pfeifer, E. C.
Pfeiffer, A. S.
Pfeiffer, O. W.
Pope, F. W.
Ritchie, Gorton
Ross, G. L.
Roth, W. C.
Rothenmaier, G. L.
Schacht, E. W.
Schacht, R. J.
Schaefer, C. O.
Schenkenberg, Grace E.
Schneller, E. J.
Schnetz, L. N.
Thackeray, R. C.
Thompson, I. F.
Tucker, I. N.
von Buddenbrock, E.
von Jarchow, B. L.
Wagner, N. B.
Walter, G. W.
Wier, F. A.
Wright, R. S.

Randolph:
Federman, E. H.
Jones, A. W.
Vetter, E. W.

Random Lake:
Malloy, T. E.
Russell, J. A.

Red Granite:
Darby, R. C.

Reedsburg:
Pawlisch, O. V.
Stadel, E. V.
Stanton, E. D.

Reedsville:
Cary, E. C.

Reeseville:
Bargholtz, W. E.

Rhinelander:
Bump, W. S.
Cline, Frances A.
Gager, W. F.
Harter, A. F.
Kaiser, L. F.
Komasinski, V. W.
Richards, C. A.
Schlek, I. E.
Schiek, I. E., Jr.
Westgate, H. J.
Wright, Marvin

Rib Lake:
Horn, A. S.

Rice Lake:
Dawson, D. L.
Hatleberg, E. J.
Rydell, O. E.
Rydell, W. B.
White, A. S.

Richfield:
Kern, T. J.

Richland Center:
Benson, G. B.
Benson, G. H.
Coumbe, W. R.
Davis, L. C.
Dull, C. F.
Edwards, W. C.
Housner, R. E.
Parke, George, Jr.
Pippin, B. I.
Sholtes, C. A.

Rio:
Maas, W. C.
Pease, W. A.

Ripon:
Cole, D. F.
Hazeltine, C. P.
Johnson, J. M.
Jones, R. H.
Leibenson, S. J.
O'Neal, Orvil
Senn, C. U.
Watson, E. L.

River Falls:
Cairns, R. U.
Davee, Chalmer
Dawson, C. A.
McJilton, C. E. J.

Roberts:
Ford, A. M.

Rosendale:
Scheid, M. M.

Rosholt:
Benn, V. A.

St. Cloud:
Kief, H. J.

St. Croix Falls:
Caldwell, H. C.
Kelly, C. A.
Riegel, J. A.

Sauk City:
Bachhuber, H. A.
Walsh, T. W.

Sawyer:
Konop, E. J.

Seneca:
Hammes, G. R.

Seymour:
Groendahl, R. C.
Hittner, V. J.
Sieb, L. H.

Sharon:
Treat, C. R.
Warrick, J. D.

Shawano:
Bauer, Frederick
Cantwell, A. A.
Cantwell, R. C.
Peterson, L. W.
Schutz, W. J.
Sebesta, A. J.
Stubenvoll, C. E.

Sheboygan:
Bock, A. B. C.
Boersma, J. J.
Carey, J. F.
Eigenberger, F.
Fiedler, O. A.
Ford, W. A.
Genter, A. E.
Glaubitz, B. J.
Greenstein, Carl
Gruenwald, Ludwig
Gunther, T. J.
Heiden, H. H.
Hildebrand, G. J.
Huibregtse, W. G.
Juckem, G. J.
Junck, J. A.
Knauf, A. J.
Knauf, G. E.
Kolb, F. K.
Kovacic, J. F.
Kraft, Siegfried
Mason, P. B.
McRoberts, J. W.
Meier, Wm. G.
Nause, F. A., Jr.
Neu, V. F.
Neumann, W. H.
Pauly, L. F.
Scheer, G. H.
Schmitt, A. J.
Schott, E. G.
Simonson, L. M.
Sonnenburg, W. M.
Squire, C. A.
Stannard, G. H.
Tasche, C. T.
Tasche, J. A.
Tasche, L. W.
Van Zanten, Wesley
Van Zanten, Wm.
Weber, C. J.
Zaegel, R. L.

Sheboygan Falls:
Hansen, H. J.
Pfeiler, A. G.

Shell Lake:
Hering, E. R.
Moen, D. V.

Shiocton:
LaCroix, G. M.

Shullsburg:
Ennis, S. A. J.
Nereim, T. J.

Silver Lake:
De Witt, C. A.

Siren:
Sherman, L. F.

Slinger:
Prefontaine, K. F.

Soldiers Grove:
Sannes, W. A.

South Milwaukee:
Chojnacki, S. L.
Crigler, R. R.
Dempsey, G. P.
Flaherty, G. S.
Oberfeld, H. H.
Rumph, C. L.
Sickels, W. A.

South Wayne:
Morrison, M. T.

Sparta:
Beebe, D. C.
Beebe, S. D.
Mannis, Harry
Phalen, C. S.
Roberts, S. M.
Scantleton, J. M.
Williams, H. H.
Williams, H. H., Jr.

Spencer:
Callahan, H. T.

Spooner:
Lemmer, G. N.
Muccilli, A. E.

Spring Green:
Nee, Frank
Wahl, C. M.

Spring Valley:
Conway, H. P.
Conway, J. M.

Stanley:
Graber, R. E.
Overgard, A. W.

Star Prairie:
Perrin, H. E.

Statesan:
Schmidt, R. H.

Stevens Point:
Anderson, H. A.
Benn, H. P.
Cowan, W. F.
Crosby, E. P.
Dunn, A. G.
Gramowski, W. A.
Gregory, W. W.
Iber, F. C.
Kidder, E. E.
Krembs, F. R.
Litzow, J. A.
Marrs, F. A.
Miller, S. R.
Rice, M. G.
Rice, R. W.
Sheehan, W. C.
Sowka, P. N.
Stollenwerk, R. J.
von Neupert, C.
Wisiol, Erich

Stockbridge:
Knauf, J. A.

Stoughton:
Keenan, H. A.
Olson, A. L.
Schoenbeck, R. F.
Smedal, A. T.

Strum:
Winter, E. F.

Sturgeon Bay:
Beck, J. G.
Dorchester, D. E.
Grota, H. D.
Huff, F. C.
Muehlhauser, J. O.

Sturtevant:
Peehn, F. G.

Sun Prairie:
McCabe, J. M.
Nelson, E. J.
Peterson, L. W.

Superior:
Averbook, M. S.
Beebe, L. W.
Carpenter, E. E.
Christiansen, C. H.
Christiansen, R. E.
Christianson, H. B.
Doyle, T. J.
Droege, C. T.
Ekblad, V. E.
Finn, Milton
Giesen, Charles W.
Giesen, Conrad W.
Goodfellow, J. R.
Ground, W. E.
Hathaway, B. J.
Johnson, F. G., Jr.
Kyllo, J. C.
McGill, J. W.
Meyers, J. M.
Myers, E. A.
O'Leary, T. J.
Orchard, H. J.
Perrin, S. H.
Sarazin, F. C.

Schnell, W. H.
Searle, D. R.
Sincock, H. A.
Wall, M. H.
Weisberg, J. H.
Wilcox, A. G.

Suring:
Dougherty, J. S.

Sussex:
Van Valin, E. C.

Theresa:
Langenfeld, P. F.

Thiensville:
Carthaus, A. H. C.
Rock, J. W.
Scholz, H. F.

Thorp:
Neis, F. P.

Three Lakes:
Hypes, F. E.

Tigerton:
Gates, A. J.

Tomah:
Bell, A. R.
Cremer, V. H.
Scheurich, L. G.
Schmidt, E. A.
Sheehy, T. J
Winter, A. E.

Tomahawk:
Baker, G. R.
Baker, R. G.
McCormick, W. C.

Turtle Lake:
Shima, R. T.

Two Rivers:
Kozelka, A. W.
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« « « EDITORIAL » » »

Blueprint For the New Year

IT IS a tradition that the editorial columns of any publication note the passing of the old year and the birth of the new, for all of us are inclined to view with mixed emotions the opportunity that is then presented to start a clean slate, with all our scribblings of the past year discarded and soon forgotten.

The profession of medicine here, as elsewhere, is ever conscious that there is no magic date permitting it the psychic use of a line of demarcation that is more nebulous than real —certainly not in the constant battle against ill health and disease. We can, however, find the occasion of a new year as an opportunity to pause a moment to reflect upon our accomplishments and our plans for the future. Of our many phased efforts, one seems to predominate above all in these days characterized as those of national emergency. The medical profession bends its every effort to serve the needs of a nation devoted to an all out war effort. The procurement of medical officers in sufficient number to provide the armed services with the best medical care available and still maintain the community health has been our grave responsibility in 1942. It becomes a graver responsibility in 1943. In the periphery of this major activity lie the efforts directed to the problems of industry, civilian defense, Selective Service, public health education, scientific studies, and countless others.

In all of these we are dominated by the thought that there must be no rationing of health in Wisconsin. In this we are boundless in our determination, but that objective cannot be accomplished by any individual organization no matter how active it may be, nor by any official or even by the community itself. It must be the objective of each individual physician keenly alert to the professional responsibilities and the part which he plays in it.

The physician must inspire the public with confidence that its needs are not overlooked but are of ever paramount importance. The greatness of the profession lies in the strength of its individual members who provide a collective security and honesty of purpose. That is the blueprint for 1943 and the years that follow.

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An Inventory

By F. E. BUTLER, M. D.
President, State Medical Society of Wisconsin

THE Woman's Auxiliary, organized in 1929, has passed its first decade of existence and is now well embarked upon the second. Upon it and its members rests a grave responsibility in this period of national emergency.

It has been said that to win the war and lose the health of the nation would be to accomplish but a partial victory, while to win the war and maintain the health of the nation would be a complete victory and one which would contribute much to the fundamental solidarity of a people devoted to a great cause.

Let us summarize for a moment the public health activities of the medical profession in which the Woman's Auxiliary must necessarily take a deep interest. Presented before the public at several of the county fairs, as well as at the State Fair, were carefully designed exhibits in the field of public health. Preparation of weekly news releases for the hundreds of newspapers in Wisconsin has been an activity of some years' standing. Committees on mental hygiene and institutional care, cancer, health and public instruction, industrial health,—these and many others devote week end after week end in their efforts to promote the public health interest of the people.

Periodically, this Society prints and distributes special material related to the broad field of public health. To mention but a few, one has only to recall the brochure on "Health Achievements in Wisconsin," the health nursery rhymes, and the supplement to the June, 1942, *Wisconsin Medical Journal* on "Health and Food," which was distributed so widely throughout the state.

Individually, physicians are constantly called upon to discuss problems of public health in their own local communities. On thousands of occasions throughout the year the physician gives much of his time and energy to the field of preventive medicine through public health education.

In these activities and with the high-minded purpose that motivates the medical profession, the Woman's Auxiliary has been of immeasurable assistance. The days that lie ahead unfold only as we come to them, and many of the problems which they hold for us are totally concealed from view. But this much we know,—all of us, as we are committed to the all out war effort, must do all that is possible individually and through the organizations we represent to carry the word of good health and preventive medicine to the people of our country. In that task the physician has for years dedicated unselfishly and, indeed, even spiritually, his seemingly boundless energies. In that, you, as the group representing the helpmates of the doctors, can render valuable assistance.

Going Into Service?

1. Notify your patients of your impending departure either by printed announcement, letter or word of mouth, *after you are commissioned.*
2. If you are planning to make arrangements for a colleague to carry on your practice, advise your patients accordingly.
3. Have your attorney draft a *written* agreement with your colleague covering contingencies likely to arise in your absence and clearly defining the terms of the arrangement.
4. See that your case histories and other records are in good order and readily available to your successor.
5. The collection of your accounts receivable should be undertaken. Turn over the more difficult accounts, *which are at least two years old,* to your attorney, and discuss the leniency to be extended on the other accounts with your successor physician and your office secretary. Friction and misunderstanding with your patients is thus avoided in many cases. Also, you may find that the mention of your departure will result in the payment of some old accounts before you go.
6. If the arrangement with your substitute does not include your office equipment, make adequate plans for its storage, lease or sale. Your county or state societies may be of assistance in locating a physician in need of your equipment.
7. Your landlord will be cooperative as to the termination or alteration of your office lease. The Soldiers' and Sailors' Civil Relief Act (see article on page 166) saves you from further liability after your departure, *if you have given proper notice.*
8. Notify the Collector of Internal Revenue, giving him your narcotics registration number, and surrender your supply of narcotics to the nearest Bureau of Narcotics office. Unopened supplies may be returned to the seller or sold to another registered physician, if the transaction is recorded on official forms.
9. Contact the hospitals on whose staffs you serve as to whether your post will be open to you upon your return.
10. Send the State Medical Society your military address, and keep the Society informed of any changes. You will continue to receive *The Wisconsin Medical Journal,* and your annual dues will be remitted for the unexpired portion of the year.
11. Your will should be critically appraised by your attorney and appropriate changes made to bring it up to date.
12. There is also the question of executing a power of attorney to your wife, attorney or trusted friend to transact necessary business for you in your absence.
13. Compute your income for the fraction of the tax year prior to your departure. While the Soldiers' and Sailors' Civil Relief Act postpones payment until after your return from service, the computation had best be made now for obvious reasons, and paid if possible.
14. Who will pay your insurance premiums in your absence? Have you investigated National Service Life Insurance, the deduction of insurance premiums from your army pay, and the law which prevents certain policies from lapsing for nonpayment while you are in service? (See article on this subject, page 169 of this issue.)

The above suggestions are prompted by the experience of others who have preceded you in service and with whom your state Society has worked diligently in an effort to avoid needless trouble and expense.

ORGANIZATION OF THE PROCUREMENT AND ASSIGNMENT SERVICE

The Procurement and Assignment Service for Physicians, Dentists and Veterinarians is under the supervision of a Directing Board composed of Dr. Frank H. Lahey, Boston, chairman; Dr. Harvey B. Stone, Baltimore, vice chairman; Dr. C. Willard Camalier, Washington, D. C.; Dr. Harold S. Diehl, Minneapolis; Dr. James E. Paullin, Atlanta. It is a part of the Office of Emergency Management, War Manpower Commission, Washington, D. C.

The Sixth Corps Area chairman is Dr. Charles H. Phifer, Chicago, and on his committee are Dr. P. R. Urmston, Bay City, Michigan, and Dr. S. E. Gavin, Fond du Lac, Wisconsin.

The Wisconsin office is directed by Dr. R. E. Fitzgerald, 2750 North Teutonia Avenue, Milwaukee, telephone number Concord 4090.

Services During 1943 Impose a Still Further Responsibility Upon Wisconsin Physicians

DR. ROBERT E. FITZGERALD, Milwaukee, state consultant for the Procurement and Assignment Service, has announced that shortly after the first of the year the Wisconsin office will develop an inventory of all physicians in Wisconsin according to the procedures outlined in a directive from the executive offices of the Procurement and Assignment Service.

The complete listing of all physicians in the state, and the obtaining of information concerning each of them, will be one of the most extensive surveys yet prepared. In order that all physicians in the state may be informed of the character of the survey, Dr. Fitzgerald obtained permission at a recent meeting of Procurement and Assignment Service officials in Chicago to permit the reprinting of the entire directive which includes certain pertinent data covering the survey and detailing the four general classifications and twenty-one subclassifications under which the physicians will be classified. Because of the importance of this matter, and so that physicians in Wisconsin may be thoroughly informed, the complete directive to Dr. Fitzgerald follows in full:

OFFICE FOR EMERGENCY MANAGEMENT

WAR MANPOWER COMMISSION

WASHINGTON, D. C.

PROCUREMENT and ASSIGNMENT SERVICE for PHYSICIANS, DENTISTS, and VETERINARIANS

December 8, 1942

To: State and Corps Area Committees

From: Directing Board, Procurement and Assignment Service

Subject: Classification of Physicians

In order that the Procurement and Assignment Service may have accurate information as to the status of the physicians remaining in civilian life, it is essential that an immediate appraisal of these physicians be made and a summary report submitted to the central office in Washington. Such a report will be requested from all state chairmen early next year. Before that time, records should be set up in local Procurement and Assignment Service offices that will furnish the information necessary for redetermination of availability and for establishment of the order of call for physicians who will be asked to seek commissions during 1943. As soon as the cards in the local offices are complete, copies are to be sent to the state chairmen who will then be in a position to compile a state report to be sent to the central office by about February 1, 1943.

For the purpose of this nation-wide report each physician should be classified in one of the following categories:

Class I. Available

A. Potentially qualified for service, i.e., has not been rejected by Army.
   1. Unmarried or married but not maintaining a home with wife and/or children.
   2. Married and maintaining a bona fide home with wife and/or children.
      a. Married with no children.
      b. Married with one child.
      c. Married with two children.
      d. Married with three or more children.

B. Not eligible, on account of age, physical disability, or other reason, for service with the armed forces, but considered available for civilian medical services associated with the war effort.

Class II. Essential for limited duration or until a replacement can be secured.

A. For community medical care.
B. For medical teaching or war research.
C. For hospital service.
D. For public health.
E. For industry.

Class III. Essential for unlimited duration.

A. For community medical care.
B. For medical teaching or war research.
C. For hospital service.
D. For public health.
E. For industry.

Class IV. Physicians not available for either military or emergency civilian services because of:

A. Physical disability or age.
B. Ethical and professional shortcomings.
C. Retirement or engagement in work not directly or indirectly connected with the field of medicine.

Class I. Physicians considered available during the war for service other than in their present situations.

Class IA. Male physicians under forty-five years of age presumably physically qualified for service, with subclasses 1 and 2 indicating the order of call in conformity with Selective Service laws and regulations. For example, a physician,

considered available, who is under forty-five years of age and maintaining a home with wife and two children would be classified as IA–2c.

Class IB. Male physicians under forty-five years of age who have been rejected for military duty but who are able to carry on civilian work, males over forty-five who might be willing to relocate, females, and aliens.

Class II. Physicians for whom it is assumed that satisfactory substitutes may be obtained and those who may be released as a result of changes in their personal situations or in conditions affecting the institutions employing them.

Class III. Essential physicians for whom, according to present conditions, the chances are small of finding a satisfactory replacement.

Class IV. Physicians who cannot be expected to contribute to medical service.

Class IVA. Physicians with marked physical disabilities, including old age, which make them incapable of practicing their profession.

Class IVB. Physicians who, because of unethical conduct or professional incompetence, are not acceptable for service in the community or elsewhere.

Class IVC. Physicians who are retired from activities connected with medical care and those who have been engaged in occupations unrelated to medicine for so long that their return to medical work is not feasible.

Criteria of Essentiality for Physicians in Community Medical Care

As a basis of planning on a national scale, an overall ratio of one effective practitioner of medicine to 1,500 population has been adopted by the Directing Board of the Procurement and Assignment Service as the minimum below which it would be unsafe to reduce civilian medical service. *In any specific area of medical practice the ratio should, as a rule, be not more than 3,000 population to one effective practitioner, particularly in military and war production areas.*

Obviously, the ratio of 1:1,500 cannot be applied to local communities or even to all states. There are many portions of the country and even some states which never have had this ratio of physicians to population. Many of these areas could not support more medical service than they have had which, in some instances, has been not more than one physician to 3,000 or 4,000 population. From such areas obviously no physicians should be withdrawn or permitted to enter the armed services unless replacements can be obtained. Indeed, in some of these areas physicians should be added. In general, the basis for the designation of physicians in private practice as available or essential will vary with the number of physicians in the community, the area of the community, and the population thereof.

Rural and Isolated Communities with Less Than 10 Private Practitioners. The following elements are to be considered: (1) Number and age of other private practitioners in the community; (2) The physician's specialty, if any; and (3) Distance from other communities with available medical facilities.

Among the practitioners under forty-five years of age, the only specialist of a kind in the community should be considered essential (IIA or IIIA) unless the distance between the community in question and another possessing similar specialists is small enough to permit these specialists to serve both communities. In general, it is to be expected that the only surgeon, the only roentgenologist, the only otorhinolaryngologist, and the only obstetrician will be declared essential even though under forty-five years of age.

Aside from the only specialists, none of the practitioners under forty-five years of age should be considered essential either temporarily or permanently for civilian medical care (Classes IIA or IIIA) except those who are needed to keep the patient load of the remaining physicians at a feasible level. This level will vary from place to place depending upon the prewar status of medical facilities in the particular community. If any physicians are to be withdrawn from such communities, their selection should be made from the physicians under forty-five years of age in accordance with the order of call outlined on page 1 (see IA—1 and 2).

In case an isolated rural community possesses only one effective practitioner, he should be declared essential irrespective of his age and placed in Class IIA or IIIA. If there are two effective practitioners in a community for which one is adequate and both are under the age of forty-five, the one who would be subject to earliest call by Selective Service should be declared available. For example, if one of two practitioners under forty-five is single and the other married with two children, the former physician is to be declared available.

For communities which are not within the transportation system of an urban center and which contain less than ten practitioners, the same considerations hold as for the rural and isolated communities. However, if the distance to the urban center can be easily traversed, the only specialist of a kind need not in all cases be classed essential.

An additional element to be considered is the flow of patients from rural and suburban communities to urban centers. As a result of this flow, communities with an inflow of patients require more physicians relatively than do those with an outflow.

Communities with Ten or More Private Practitioners. The factors to be taken into account include: (1) Number and age of effective private practitioners; (2) Geographic distribution of practitioners (especially in the large cities); (3) Inflow of patients from outside the city; and (4) The physician's specialty.

The inflow of patients to urban communities for medical care may in certain cases be considerable,

and allowance should be made for this in determining the potential patient load of the physicians of the community.

Practicing physicians under forty-five years of age who are not essential to medical schools, hospitals, public health services, or war industries will be considered available in Class IA or IB except for the number needed to carry the patient load in excess of that which the physicians forty-five years and older can handle. If some physicians under forty-five are to be considered essential, they should be selected in conformity with the order of call, outlined on page 1 above.

Specialists under forty-five years of age in urban communities are usually available unless they are on the essential lists of hospitals or medical schools or unless their practice is limited to outlying districts or circumscribed communities within the city which cannot be adequately served by other practitioners in the same specialty.

Criteria of Essentiality for Institutions and Related Groups

In determining the essentiality of a physician whose professional activities are part of those performed by an organized medical group, whether hospital, medical school, industrial organization, or independent group clinic, due consideration should be given to the physician's contribution to the completeness of the service given by the group. An organization is more than the sum of its component parts; physicians who work together must therefore be considered in relation to the importance of the individual physician to the adequacy of the medical service given by the institution. The total contribution of the medical service given by the institution or organization shall also be considered in relation to the total population served by the institution, clinic, or organization, compared with the contribution of other medical facilities and the population served.

Criteria of Essentiality for Medical Teaching and Research. The Procurement and Assignment Service has recommended that medical schools should limit the size of their faculties to the minimum number essential for the conduct of an adequate teaching program. Lists of faculty members considered essential on this basis have been submitted to the Procurement and Assignment Service by the deans of the respective medical schools (form #91, June 15, 1942.)

Criteria of Essentiality for Hospital Service. On August 12, 1942, a questionnaire (form #109) was sent to administrators of hospitals approved for internships and/or residencies, requesting a list of essential members of hospital staffs and giving broad criteria of essentiality. On October 12, 1942, a memorandum (form #140) was sent to deans of medical schools giving instructions about the commissioning of interns in the Army and the Navy.

Full-Time Staff

Interns. Under authorization of the Surgeon General of the Army and the Surgeon General of the Navy, medical school graduates are allowed one year of internship to be completed within the twelve months following graduation before being called to active duty. During this period they need not be considered with the essential hospital staff unless their number affects the number of other staff members required by the hospital (see form #109, August 12, 1942, and form #140, October 12, 1942).

Residents. In certain hospitals residents are definitely essential for the adequate care of patients and/or the clinical instruction of medical students. However, in view of the urgent need of the Army and the Navy for young medical officers, the number of residents listed as essential must be kept to the absolute minimum. For 1942 the Directing Board of the Procurement and Assignment Service has suggested that the number should be reduced by at least 50 per cent of the number of residents the hospitals had before the war. For 1943 this number must be reduced still more. Having determined the minimum number of residents that are essential, selection should be made from the following groups in the order indicated: (1) Physicians who cannot qualify for service with the Army or the Navy; (2) Present interns or residents who are deferred by Selective Service. In this group preference should be given to those who are deferred in Class IVF or Class IIIB (Selective Service classification); (3) Present interns who hold commissions in the Army or the Navy. No assurance can be given that deferment of active duty will be permitted for this group. If it is, each case will have to be certified as essential by the State and Corps Area Committees of the Procurement and Assignment Service.

The essentiality or availability of other staff physicians should be considered in relation to (1) the established function of the hospital, and (2) the special qualifications of the physician and the services rendered by him. The need for physicians will differ according to the type of hospital or related institution, such as a general hospital, a tuberculosis sanatorium, or a home for the aged. They will be different also for a general hospital with public wards from one admitting only pay or part-pay patients. Only those full-time members of hospital staffs should be classed as essential who are responsible for the execution of the established activities of the institution. A physician designated as full-time who limits his services to the care of his own patients is not necessarily to be regarded as essential to the hospital.

Part-Time Staff

Following the same line of reasoning, a physician giving only part-time service to a hospital or one designated as visiting physician may be regarded as essential to a particular hospital only if he is rendering necessary services which cannot be supplied by other physicians in the community.

Criteria of Essentiality in Public Health. In a memorandum dated August 22 (form #123) the Directing Board authorized the rating of "essential" for the heads of the health departments of administrative units such as cities, states, and counties; and for the chiefs of bureaus within the health departments of the individual political units. Such individuals will, therefore, be placed in Class III or II depending upon the possibility of replacement. The determination of the essentiality or availability of the physicians, who occupy lower ranks than those above, or who are engaged part-time in public health work, will depend upon the nature of their work, the needs of the community, and the special qualifications of the individuals for the kind of services they render. Special consideration should be given to the importance of these services to the health programs in communities directly affected by the war either through large population increases or through the loss of physicians.

Criteria of Essentiality in Industrial Medicine. In a memorandum dated August 22 (form #121), the Directing Board authorized the rating of "essential" for two groups of industrial physicians. First, full-time chiefs of State Industrial Hygiene Bureaus and key members of their staffs. Second, certain physicians working in industries which produce priority materials. These physicians must (1) give their full time to this work, (2) have been so employed for two years (or have been especially trained), (3) be carrying on an acceptable program, and (4) be ranked as medical directors or department heads. Assistants may be temporarily deferred at the request of the directors until replacements can be found. Physicians who are "on call" for industrial service are not to be considered as essential, except those who devote a great part of their time to a number of small plants. In such cases they should be classified as essential until other arrangements can be made for the care of the workers. Men under the age of thirty-eight should not be considered essential in industry except under most unusual circumstances.

Washington, D. C.
December 16, 1942

Mr. C. H. Crownhart
110 East Main Street
Madison, Wisconsin

Dear Mr. Crownhart: The Directing Board of the Procurement and Assignment Service suggests that you publish the following statement on the cover page of the next issue of your Journal, or in some other prominent position. The Board deeply appreciates the support, help, and cooperation always received from you.

"It is of the utmost importance that the Procurement and Assignment Service for Physicians, Dentists, and Veterinarians, immediately has the name of any doctor who really is willing to be dislocated for service, either in industry or in over-populated areas, and who has not been declared essential to his present locality. This is necessary if the medical profession is to be able to meet these needs adequately and promptly. We urgently request that any physician over the age of forty-five who wishes to participate in the war effort send in his name to the State Chairman for the Procurement and Assignment Service in his state."

Sincerely yours,
FRANK H. LAHEY, M. D.
Chairman, Directing Board

The Amended Soldiers' and Sailors' Civil Relief Act

THIS law, which was enacted in 1940, has been amended three times during 1942, the last amendment having been approved as recently as October 21. It is designed to protect all persons after the date of beginning active military service from legal proceedings based on obligations incurred prior to entering the service. Those included in its protection are persons in the Army, Navy, Marine Corps, Coast Guard, and officers of the public health service detailed for duty with the armed services.

The act is of direct practical importance to all persons entering the service, including physicians. It has earlier been discussed in the 1942 Blue Book contained in the December, 1941, issue of *The Wisconsin Medical Journal,* beginning at page 1170, and in the March 1942 *Journal,* at page 230. However, the amendments are so substantial and are so important to physicians entering the service, that it has seemed advisable to rewrite the article.

The purpose of the legislation, as stated by Congress, is to enable persons in military service to

devote their entire energy to the defense needs of the nation. While the act operates as a temporary suspension of legal proceedings, it does not cancel the obligation itself.

The act provides that its protection shall continue until the date of discharge from active service or death of the person while therein, or until the expiration date of the act, which is stated to be May 15, 1945; or, if the United States is then at war, until six months after peace is proclaimed.

Sureties, endorsers, guarantors and the like may, in the discretion of the court, be extended the same relief as that granted to their principals, as well as accommodation makers and others, whether primarily or secondarily liable.

General Relief

In general the act provides, in section 200, that before any default judgment may be entered in any court, state or federal, whether a court of record or not, the plaintiff must file an affidavit setting forth facts showing that the defendant is not in military service, that he is in such service, or that the plaintiff is unable to determine the fact. Unless an affidavit is filed showing that the defendant is *not* in military service, no judgment shall be entered without a court order directing such entry. If the defendant is in military service no order directing entry of judgment shall be made until the court has appointed an attorney to represent the defendant. His acts, however, do not bind the defendant. Sec. 200 (3). Unless it appears affirmatively that the defendant is not in military service, the court may require as a condition to the entry of judgment, a bond to indemnify the defendant against any loss or damage should the judgment later be set aside in whole or in part. The court may make such further order as seems to it necessary to protect the rights of the defendant under this act. To get the judgment reconsidered, there must be a "meritorious or legal defense," and application must be made not later than ninety days after termination of service.

Bona fide purchasers for value under such a judgment which is subsequently vacated or modified, are, however, not affected. Sec. 200 (4).

The court may on its own motion, and must on request by or on behalf of a person in service, (a) stay any action or proceeding involving such a person, (b) stay the execution of any judgment or order entered against him and/or vacate or stay any attachment or garnishment of his assets, unless it believes that his ability, in case (a), to prosecute or to defend, or in case (b), to comply with the judgment or order entered or sought "is not materially affected by reason of his military service." Sec. 201 and 203.

There shall be no penalty where an action for noncompliance with any contract is stayed; and where a person fails to perform any obligation and a fine or penalty is incurred therefor, the court may, on such terms as may be just, relieve against the enforcement of the fine or penalty if it shall appear that the person was in military service when the penalty was incurred, and thus, by reason of such service, his ability to pay or perform was materially impaired. Sec. 202.

The period of military service shall not be included in computing the running of statutes of limitation, as to actions or proceedings by or against any person in military service, whether the right to bring the action accrued prior to or during military service. The result is that actions for malpractice may be stayed, and the physician's right to sue for collection of accounts is extended until his return. However, it is doubtful whether the statutory period of redemption from foreclosure of a real estate mortgage is extended by the act, since this right has been ruled to be primary rather than procedural, and the act is designed to apply only to the latter.

Leases

Without leave of court granted upon application therefor, or granted in an action affecting the right of possession, no eviction shall be made during the period of military service as to any premises for which the agreed rent does not exceed $80 per month and which are occupied chiefly for dwelling purposes by the wife, children, or other dependents of a person in military service. Sec. 300. But the Secretaries of War, Navy and Treasury, as the case may be, are empowered to order a reasonable allotment of pay for rent. Sec. 300 (4).

Another new section provides that where a landlord's action for distress or eviction is stayed or otherwise affected by court order, he shall be entitled, upon application to the court, to relief with respect to the premises similar to that granted to persons in military service, and to such extent and for such period as may appear to be just.

Any lease covering professional or residential property executed prior to the entry of the obligor into military service and actually occupied for such purposes by the person entering the service, or by him and his dependents, may be terminated by notice in writing to the lessor or his agent at any time following the date upon which military service begins. If monthly payment of rent is required by the lease, termination is not effective until thirty days after the first date on which the next rental payment is due and payable, subsequent to the date that notice is given. In all other cases termination is effective on the last day of the month following the month in which notice is given, and rental prepaid or unpaid is to be prorated and paid or refunded as the case may be.

Installment Contracts

The act provides that no real or personal property sold under an installment contract may be repossessed, or other steps taken to rescind or terminate the contract for nonpayment of any installment or for any other breach of the contract except

by an action brought in a court of competent jurisdiction. However, the protection of this proviso extends only to contracts upon which a deposit or installment payment upon the contract has been made prior to the military service of the debtor. The court hearing the matter may order repayment of prior installments or deposits as a condition of terminating the contract and repossessing the property, or may on its own motion, and shall on application to it by the person in military service, or some person in his behalf, stay the proceedings, unless in its opinion the ability of the person in military service to comply with the contract terms is not materially affected by reason of such military service. It no longer matters whether the contract was entered into before or after the effective date of the act.

Mortgages and Land Contracts

If the obligation originated prior to entry into military service, similar relief and stays of proceedings may be afforded persons in service as to mortgages or land contracts on real estate or personal property, provided that the property is owned by the person when military service began and is still owned by him when enforcement of payment is attempted.

Income and Property Taxes

With the exception of employes subject to the Federal Insurance Contribution Act, the collection of income taxes from any person in military service, whether the tax falls due prior to or during the service, shall be deferred for a maximum period of six months after termination of service, if his ability to pay the tax is materially impaired thereby. No interest or penalties may be charged for the extension, but the statute of limitations on actions to collect the tax shall also be suspended during military service and for nine months thereafter.

To prevent multiple taxation, a 1942 amendment provides that for purposes of property, income, or other taxation of a person in military service, such person shall be deemed not to have lost the legal residence or domicile which he had prior to such military service, by reason of his absence therefrom, and shall not be deemed to have acquired residence or domicile in any other state in which he may be stationed under military or naval orders during the period of his service. To illustrate, suppose that a Wisconsin physician should be stationed in succession for one year in Alabama, one year in Texas, and one year in Hawaii. At no time during such period of service does Alabama, Texas, or Hawaii obtain authority to tax his income or property (unless, of course, he should actually buy a home or otherwise make active investments in such places). He continues for property, income, and other tax purposes to remain a resident of Wisconsin throughout his period of military service, no matter where he may in fact be stationed.

Property of a person in military service is exempt from sale to enforce the collection of a tax or assessment except by leave of the court, which also may grant a stay of proceedings or sale up to six months after termination of military service, unless the court is satisfied that the ability of the person in military service to pay such taxes is materially affected by reason of such service. It is no longer necessary that an affidavit be filed with the tax authorities establishing the owner's inability to pay by reason of military service. Personal property as well as real estate owned and occupied by the person in military service for dwelling or professional services is included where such property continues to be occupied during the period of his military service by his dependents or his employees.

Miscellaneous Provisions

The foreclosure or enforcement of any lien for storage of household goods, furniture, or personal effects of a person in military service and for three months thereafter is forbidden except upon court order.

No obligation bearing interest at a rate in excess of 6 per cent shall bear the higher rate unless the court decides that military service has not materially impaired the person's obligation to pay it.

The extremely important question of what happens to the life insurance of the physician in service is separately treated in an article beginning on page 169 of this issue.

There is an important general provision to the effect that should it appear to the court that any interest, property or contract has since the date of approval of the act been transferred or acquired with the intent to delay the just enforcement of such right by taking advantage of the act, the court may entirely ignore the protection which it might otherwise give.

One of the most important of the 1942 amendments is that which extends certain of the benefits of the act to the *dependents* of a person in military service, except in cases where a court finds that the ability of such dependents to comply with the terms of an obligation, contract or lease, has not been materially impaired by reason of the military service of the person upon whom the applicants depend. The benefits covered are those having to do with rent, leases, installment contracts, mortgages and liens.

A new amendment provides for waiving the protection of the act if the waiver is executed as a separate instrument and at a time, or after the time, when the person waiving is in the military service. Contracts, leases, or obligations secured by mortgage, trust deed, and the like are included, as is repossession, foreclosure and sale of property which is security for the payment of an obligation. A like waiver may be given by principal signers, sureties, accommodation makers, and the like, so long as such waiver is given prior to military serv-

ice by such signer, or during his military service, if the waiver be executed by a dependent of the signer.

Further Relief

In conclusion, attention is called to another important 1942 amendment which permits a person at any time during his military service, or within six months thereafter, to apply to a court for relief as to any obligation or liability incurred prior to the period of military service, or in respect to a tax or assessment, whether falling due prior to or during the period of military service. The court may grant relief in such cases unless it decides that the ability of such person to comply with the terms of such obligation was not materially affected by reason of the military service.

In the case of land contracts or real estate mortgages, the enforcement of such obligation may be stayed during the period of military service and after its termination, or if the application is made after military service, a stay may be granted equal to the period of the remaining life of such contract, plus additional time equal to the period of military service, with appropriate rescheduling of the installments.

In the case of any other obligation the court may grant a stay of enforcement during the period of military service, or from the date of application if made after such service, for a time equal to the period of military service of the applicant, with an appropriate rescheduling of installments.

Where such a stay of proceedings is granted, no fine or penalty may accrue during such period of extension so long as the terms and conditions of such extension are fulfilled.

The 1942 amendments were clearly designed to meet most of the objections which had earlier been raised to the act as drafted in 1940. As now amended, the act can fairly be said to provide a means for removing much of the worry and uncertainty incidental to the interruption of the civilian professional life of physicians and others comparably situated.

Life Insurance and the Physician in Service

IN COMMON with other professional groups, physicians depend very largely upon their life insurance programs both for their personal independence in later years and for the financial self-sufficiency of their families. Accordingly, the subject of insurance, as it is affected by military service, is a matter of very real importance to the profession. The problem has two aspects. The first is the provision made for existing personal life insurance programs. The second is the provision made by the government for carrying additional coverage for the benefit of those in service. The subject will be considered in that order.

I. RELIEF AS TO PERSONAL INSURANCE PROGRAMS

War Risks Exclusion Clauses

Practically all private life insurance policies which have been written since the fall of 1941 have carried a so-called "war risks exclusion" clause. This ordinarily takes one of three forms. It may provide that the insurance company shall not be liable for payment if death occurs while the insured is in the armed forces of the government in time of war. Still another type of clause is that providing that the insurance company shall not be liable for payment in case of death which occurs as a result or in consequence of military service. The third common type of clause provides that the company shall not be liable for death occurring while the insured person is "engaged" in military service.

It is clear that in the case of policies which contain war risks exclusion clauses the liability of the insurance company depends both on the wording of the clause and on the cause of death. Some companies will insure against war risks but in so doing exact an additional premium which more than doubles the ordinary cost of such policy. This type of limitation has the effect of rendering much insurance written for a man of military age of doubtful potential value to his family or estate.

Still another reason why physicians of military age view with some concern their personal life insurance programs at this time is the uncertainty that they will be financially able to maintain such programs in force during their period in the armed service of the country. The severe reduction in income which attends the giving up of an active medical practice makes it inevitable that a substantial portion of an individual life insurance program can be carried only by borrowing, or may even have to lapse.

Relief for Service Men

In the October, 1942, issue of *The Wisconsin Medical Journal* the personal life insurance program of the physician in service was discussed in an article beginning at page 917. That same month amendments to the federal Soldiers' and Sailors' Civil Relief Act of 1940 were adopted which completely revised the law of two years ago, thereby necessitating the rewriting of that portion of the article.

The act as amended, in effect, gives to persons in active military service a moratorium on premiums

on personal life insurance in an amount not exceeding $10,000. The amendments cover policies taken out before October 6, 1942, or on which premiums were paid not less than thirty days before entry into service, which policy or policies are in force at the time application is made for benefits under the act.

The twofold purpose of the amendments is to protect an insured individual against the lapse or forfeiture of his policies up to $10,000, subsequent to the date of an approved application, while he is in service and for two years after his discharge, and to guarantee insurance companies against loss arising out of nonpayment of premiums during such period.

Physicians will welcome the news that the Federal Government will now guarantee the payment of premiums on $10,000 instead of $5,000, which was the maximum under the 1940 law.

If an insured individual makes application for protection of policies on his life totalling in excess of $10,000, the Veterans' Administration is authorized to have a given amount of insurance divided into two or more policies, so that the total amount of insurance so guaranteed by the Government does not exceed that maximum.

No dividend or other monetary benefit under a policy may be paid to an insured or used to purchase dividend additions while a policy is protected by the provisions of the act, except with the consent of the Veterans' Administration. No cash value, loan value, or withdrawal of dividend accumulation, or unearned premium, is available to the insured while the policy is protected under the act, except upon approval of the Veterans' Administration. However, the insured's right to change a beneficiary or to select an optional settlement is not affected by the fact that the policy is under the protection and guarantee of the United States Government.

Where a policy becomes payable by reason of death or otherwise before expiration of the period of protection, the insurance company in making settlement may deduct from the amount otherwise payable the premiums guaranteed by the Government, together with interest thereon at the rate fixed in the policy for policy loans.

If at the time the protection guaranteed by the United States on a given policy or policies expires, the amount of unpaid premiums is not in excess of the loan value of such policy, such unpaid premiums shall be treated as a policy loan. But if the cash surrender value be less than the amount due at the time such insurance protection ceases, the United States Government guarantees to pay the insurer the difference.

An insured individual who is in active military service, or a person designated by him, or, in case the insured is outside the United States, (excluding Alaska and the Panama Canal Zone) a beneficiary may make application for the benefits provided by the amended act by sending the original of an application for benefits to the insurance company and a copy to the Veterans' Administration at Washington, D. C. Application forms are obtainable from the Veterans' Administration or, ordinarily, at the camp or station of the man in service. If any difficulty should be encountered in a particular case, especially where individual beneficiaries of men now in foreign service are concerned, the Society will be glad to render every service possible to such individuals.

In the case of a policy on the life of a person in military service which was assigned prior to such person's period of military service to secure the payment of any obligation of such person, no assignee of such policy (except the insurance company in connection with a policy loan) shall, during the period of military service of the insured individual, or within one year thereafter, except (1) upon the consent in writing of the insured made during such period, or (2) when the premiums on such policy were due and unpaid, or (3) upon the death of the insured, exercise any right or option growing out of such assignment except upon authority of a court. The court may refuse to grant such leave to the assignee of a policy unless in its opinion the ability of the insured party to comply with the terms of the obligation is not materially affected by reason of his military service. Insurance premiums which are guaranteed by the United States Government are *not* considered to be due and unpaid. In other words, only policies which were not guaranteed by the Government could be treated in the category of delinquent for nonpayment of premiums.

The 1942 amendments above summarized are highly desirable from the point of view of physicians and others who may enter the service. It is suggested that the physician continue in force as much of his own insurance program as he can, but that in the case of expensive insurance, particularly that which the physician desires to keep active, he make application for the benefits of the act, or have his attorney in fact or beneficiary do so.

II. NATIONAL SERVICE LIFE INSURANCE

Introduction

To provide life insurance in amounts from $1,000 to $10,000 for persons in the active service of the armed forces of the United States there was enacted two years ago a statute known as the "National Service Life Insurance Act of 1940." This was enacted in anticipation of the perils incident to service in our armed forces either under the Selective Service Act or during a state of actual war, it being appreciated it would be impossible for men in service to procure adequate life insurance from private carriers except at extremely high rates. An outstanding difference between the War Risk Insurance Act of 1917 and the 1940 act is that the former provides for benefit payments in the event of total and permanent disability, as well as in the case of death,

Cornerstones

ONLY THROUGH ABILITY TO ESTABLISH AND MAINTAIN HIGH STANDARDS AND TO CONTRIBUTE NEW AND USEFUL PRODUCTS FOR THE CONTROL OF DISEASE CAN A PHARMACEUTICAL MANUFACTURER BECOME A HELPFUL FACTOR IN WORLD MEDICINE

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whereas the recent act does not. The 1940 act provides only for life insurance. However, it does provide that payment of premiums is waived during the continued total disability of a service man which began subsequent to the effective date of his insurance, and which continued for six consecutive months or more prior to the insured's sixtieth birthday.

A 1941 amendment provides automatic insurance, if no government insurance had been in force, against death in line of duty in active service in an aggregate amount of $5,000 where such death occurred between October 8, 1940 and April 19, 1942. A 1942 amendment goes even farther by providing in the case of men in service who have in fact not applied for insurance, that $5,000 shall be deemed to be in force, with waiver of premium, during a period of total disability as a result of injury or disease incurred in line of duty, where such disability continues without interruption for six months, such premium waiver to continue until six months after total disability ceases, so long as such date is not later than April 21, 1943.

A second 1942 amendment places in force $5,000 in insurance on those who did not have that much in force under the National Service Life Insurance Act, or under the prior acts of 1917, or 1924, in all cases of men subjected to capture, siege, or isolation between December 7, 1941 and April 20, 1942. Premiums on such insurance shall be waived during the period that such insured person remains captive, besieged, or isolated, and for six months thereafter. The humanitarian purpose and intent of these amendments are self evident.

Persons Insurable

Any person in active service in the land or naval services of the United States, including the Coast Guard, is entitled to apply for national life insurance if such person is serving under orders to active duty not limited to a period of less than thirty-one days.

Any person in active service on December 20, 1941, could apply for insurance without the requirement of a medical examination up to April 19, 1942, but after that date would have to pass a medical examination. Persons entering active service after December 20, 1941, have 120 days within which to apply for national service life insurance without medical examination.

It is strongly urged that a physician apply for insurance as soon as he enters upon active duty. It is uncertain whether he has a right to increase or decrease the amount of insurance originally asked for, as the act is silent on this question. However, there are known instances where increases have been allowed, but this is not true of decreases. The insurance becomes effective upon the date specified in the application but not later than the first day of the calendar month following the date of application.

It is prudent to have the insurance take effect immediately since the government is not liable in the case of death which intervenes between the date of application and the date the insurance was to take effect, if those dates are not the same. Thus, if a physician applied for insurance on October 1 to be effective November 1, and died October 15, there would be no liability on the part of the government. If, however, he had applied September 1 and had stipulated that the insurance take effect as of that day, the government would be liable were his death to occur on September 15.

Beneficiaries

If no beneficiary is designated in the policy, the proceeds are payable in the following order to the following person or group surviving the deceased insured: widow, child or children, parent or parents, brothers and sisters. If none of the above persons or groups survive, the government will make no payment. The insurance is not payable to the estate of the insured person in such a situation as was true under the 1917 act.

If the insured person desires to designate a beneficiary he is limited to the above classes and to stepchildren, to illegitimate children, and to relatives or others who have given him a home or otherwise taken the place of natural parents.

It is uncertain whether insurance under the 1940 act is payable to an adopted child or to adopted brothers and sisters, stepbrothers and stepsisters, and sisters and brothers of the half-blood. Under a 1942 amendment a father or mother by adoption may expressly be included as a beneficiary. The information booklet issued by the Veterans Administration, dated August, 1941, and designated as "Insurance Form 398," states that an adopted child may be a beneficiary. While this is a desirable administrative ruling, it is not certain that the courts will so hold under the wording of the act.

The service man carrying national service life insurance has the right at all times to change the beneficiary or beneficiaries without the consent of the latter. Under the act the beneficiary has no vested or property rights in the proceeds of the insurance, even under a contract whereby the insured agrees not to change the beneficiary.

Cost and Conversion of Service Insurance

The cost of national service life insurance varies between 67 cents per month per $1,000 for a man of twenty-four and $1.27 per month per $1,000 for a man of fifty. Since a physician going into service will seldom be less than twenty-four, and few of them will be more than fifty these examples of monthly costs should suffice to indicate the range. The rates rise rather rapidly for men over fifty.

This service insurance is five year, level premium, term insurance, without any cash value during the term period. The privilege of conversion to policies of national service life insurance on ordinary life, twenty payment life, or thirty payment life plan is permitted any time between the end of the first

The swaddled infant pictured at right is one of the famous works in terra cotta exquisitely modeled by the fifteenth century Italian sculptor, Andrea della Robbia. In that day infants were bandaged from birth to preserve the symmetry of their bodies, but still the gibbous spine and distorted limbs of severe rickets often made their appearance.

A bambino from the Foundling Hospital, Florence, Italy,—A. della Robbia

Glisson, writing in 1671, described an ingenious use of swaddling bands — "first crossing the Brest and coming under the Armpits, then about the Head and under the Chin and then receiving the hands by two handles, so that it is a pleasure to see the Child hanging pendulous in the Air . . . This kind of Excercise . . . helpeth to restore the crooked Bones. . . ."

STRAPPED FOR RICKETS

SWADDLING was practised down through the centuries, from Biblical times to Glisson's day, in the vain hope that it would prevent the deformities of rickets. Even in sunny Italy swaddling was a prevailing custom, recommended by that early pediatrician, Soranus of Ephesus, who discoursed on "Why the Majority of Roman Children are Distorted."

"This is observed to happen more in the neighborhood of Rome than in other places," he wrote. "If no one oversees the infant's movements, his limbs do in the generality of cases become twisted. . . . Hence, when he first begins to sit he must be propped by swathings of bandages. . . ." Hundreds of years later swaddling was still prevalent in Italy, as attested by the sculptures of the della Robbias and their contemporaries. For infants who were strong Glisson suggested placing "Leaden Shooes" on their feet and suspending them with swaddling bands in mid-air.

How amazed the ancients would have been to know that bones can be helped to grow straight simply by internal administration of a few drops of Oleum Percomorphum. What to them would have been a miracle has become a commonplace of science. Because it can be administered in drop dosage, Oleum Percomorphum is especially suitable for young and premature infants, who are most susceptible to rickets. Derived from natural sources, this product is rich in vitamins A and D. Important also to your patients, Oleum Percomorphum is an economical antiricketic.

EXIGENCY OF WAR

Oleum Percomorphum 50% is now known as Oleum Percomorphum 50% With Viosterol. The potency remains the same; namely, 60,000 vitamin A units and 8,500 vitamin D units per gram. It consists of the liver oils of percomorph fishes, viosterol, and fish liver oils, a source of vitamins A and D in which not less than 50% of the vitamin content is derived from the liver oils of percomorph fishes (principally Xiphias gladius, Pneumatophorus diego, Thunnus thynnus, Stereolepis gigas, and closely allied species).

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and prior to the expiration of the fifth year of the term. Unless converted on or before expiration of the five year term period, the insurance ceases and terminates on the latter date. The ordinary life policy will be payable throughout the lifetime of the insured, as is true of insurance with private companies. A twenty payment life contract pays up the policy after twenty years, and a thirty payment life contract does likewise after thirty years.

Payment of Benefits

The proceeds of a national service life insurance policy are not paid or payable in their face amount at the time of the death of the assured but are distributed in equal monthly installments over a period of ten or twenty years according to the age of the beneficiary. If the beneficiary to whom payment is first made is under thirty years of age at the time of death of the insured, payment shall be made over a twenty year period in 240 equal monthly installments at the rate of $5.51 for each $1,000 of insurance.

If the beneficiary to whom payment is first made is thirty or more years of age at the date of death of the insured, payment is made over a ten year period in 120 equal monthly installments in accordance with a schedule based upon the American experience table of mortality, with interest at 3 per cent. The amounts so paid vary from $3.97 a month per $1,000 of insurance in the case of a beneficiary thirty years of age, to $9.61 per $1,000 per month in the case of a beneficiary eighty-five years of age.

Upon proof of death of the first beneficiary, monthly installments shall thereafter be made in the same amount to the person or persons next entitled to receive the proceeds, until all of the installments shall have been paid. Neither the statute nor the regulations thus far disclose what is to be done if there are two or more persons in one class, one of whom is under thirty and one over thirty, when the first monthly installment is paid, but this will be worked out in time.

Medical Officers' Pay, Allowances and Rank

THE physician entering the armed forces of his country necessarily will have certain new circumstances to meet among which will be that of financial adjustment. At least a summary understanding is necessary if the prospective Army or Navy doctor is to minimize the difficulties attendant upon this problem. The facts presented here are condensed from a recent War Department bulletin dealing with the Pay Readjustment Act of 1942.

Base Pay

Pay periods are prescribed, and the base pay for each is fixed as follows: The first period, $1,800; the second period, $2,000; the third period, $2,400; the fourth period, $3,000; the fifth period, $3,500; and the sixth period, $4,000.

The pay of the first period shall be paid to second lieutenants of the Army and to ensigns of the Navy, the second period to first lieutenants of the Army and to lieutenants (junior grade) of the Navy, the third period to captains of the Army and to lieutenants of the Navy, the fourth period to majors of the Army and to lieutenant commanders of the Navy, the fifth period to lieutenant colonels of the Army and to commanders of the Navy, the sixth period to colonels of the Army and to captains of the Navy.

Every officer shall receive an increase of 5 per cent of the base pay of his period for each three years of service up to thirty years.

Rent Allowance

An officer having one or more dependents is entitled to the following rent allowance: first period, $60 per month; second period, $75 per month; third period, $90 per month; fourth period, $105 per month; fifth or sixth period, $120 per month.

An officer having no dependents is entitled to the following rent allowance: first period, $45 per month; second period, $60 per month; third period, $75 per month; fourth period, $90 per month; fifth or sixth period, $105 per month.

No rent allowance is allowed an officer who is assigned to quarters at his permanent station, nor is an officer without dependents entitled to a rent allowance when on field or sea duty.

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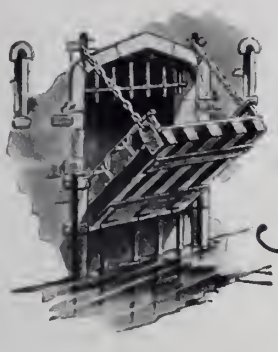

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Subsistence

Each commissioned officer below the grade of brigadier general or its equivalent shall be entitled at all times, in addition to his pay, to a money allowance for subsistence. The value of one subsistence allowance is fixed at 70 cents a day. To each officer receiving the base pay of the first, second, third, or sixth period the amount of this allowance is equal to two subsistence allowances (or about $42 a month). To each officer receiving the base pay of the fourth or fifth period the amount of this allowance equals three subsistence allowances (or about $63 a month). An officer with no dependents is entitled to only one subsistence allowance (or about $21 a month).

Foreign Service

The base pay of any commissioned officer is increased by 10 per cent while that officer is on sea duty or on duty in any place beyond the continental limits of the United States or in Alaska, which increase is in addition to pay and allowances otherwise authorized. This provision will remain in effect until twelve months after the termination of the present war is proclaimed by the President.

An officer with dependents who is assigned to foreign service, or to duty in a theatre of operations within the United States or Alaska where his family may not accompany him, continues to receive his usual rent and subsistence allowances. However, out of his subsistence allowance he must pay his own subsistence expenses, but his rent allowance and the balance of his subsistence allowance may go to his dependents.

Uniform Allowance

Any officer originally commissioned below the grade of major is allowed $150 for uniforms. This allowance is granted *after* the officer is in service.

This amount will not by any means cover the entire cost of uniforms, but is intended to compensate only for minimum requirements.

Uniforms may be obtained from the post exchange or from the quartermaster stationed on the post. The wisest procedure would be to buy only one uniform before reporting for duty and then complete the wardrobe after arriving at the post.

Travel Allowance

An officer travelling under competent orders without troops shall receive a mileage allowance of 8 cents a mile, distance to be computed by the shortest usually travelled route. Actual expenses only shall be paid for travel under orders in Alaska and outside the limits of the United States in North America. An officer travelling by privately owned conveyance shall be entitled, in lieu of transportation by the shortest usually travelled route, to a money allowance at the rate of 3 cents a mile for the same distance.

When any officer having dependents is ordered to make a permanent change of station, the United States shall furnish transportation in kind from funds appropriated for the transportation of the various branches of the service.

Promotion

The chances for promotion, under existing conditions, are favorable. The old system of seniority has been superseded by "selection on merit." Recommendations for promotion are made by commanding officers on the basis of ability and performance.

An officer may be promoted only one rank at a time and only to fill an existing vacancy. Such vacancies are numerous because of the rapid expansion of the Army and Navy.

Duration of Commission

All new physician appointments to commissioned ranks are for the duration of the war, plus six months. The Army of the United States includes the Selective Service Army as well as the Regular Army and its organized naval and other reserves. It is mobilized for the purpose of fighting the war and ceases to exist six months after the termination of the war.

Medical Advisory Boards

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BOARD NO. 1

Local boards served.—*Milwaukee city, local boards nos. 1, 2, 3, 4, 6, 10, 15, 16, 19*

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BOARD NO. 2

Local boards served.—*Milwaukee city, local boards nos. 7, 9, 13, 18, 20, 21, 22, 25, 26*

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BOARD NO. 3

Local boards served.—*Milwaukee city, local boards nos. 5, 8, 11, 12, 14, 17, 23, 24, 27*

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BOARD NO. 4

Local boards served.—*Milwaukee county, outside city limits of Milwaukee, Waukesha, Ozaukee*

Millard Tufts (chairman), 208 E. Wisconsin Ave.; Edward L. Tharinger (secretary), 231 W. Wisconsin Ave., Milwaukee; Merle Q. Howard, Wauwatosa; Milton C. Borman, Urban J. Durner, Chester C. Schneider, Dexter H. Witte, Hans W. Hefke, N. W. Bourne, Maurice J. Reuter, and Robert P. Montgomery, all of Milwaukee; James F. Wilkinson, Oconomowoc; and A. T. Wiebrecht (dentist), Milwaukee.

BOARD NO. 5

Local boards served.—*Walworth, Racine, Kenosha*

Russell M. Kurten (chairman), Racine; Harold B. Keland (secretary), Racine; Kenneth C. Kehl, Racine; T. W. Ashley, Kenosha; Henry B. Beeson and L. E. Fazen, Racine; Stilwell G. Meany, East Troy; Charles E. Pechous and Irwin E. Bowing, Kenosha; Elmore W. Goelz, Whitewater; Charles F. Ulrich, Alfred L. Mayfield, and Cyril G. Richards, Kenosha; F. W. Peil (dentist), Racine; and George C. Gabe (dentist), Kenosha

BOARD NO. 6

Local boards served.—*Jefferson, Rock, Green, Lafayette*

Aubrey H. Pember (chairman), Janesville; Thomas J. Snodgrass (secretary), Janesville; Emmett W. Bowen, Watertown; W. A. Munn, Janesville; Nathan E. Bear, Monroe; Wm. J. Allen and Russell F. Wilson, Beloit; and C. T. Foote (dentist), Janesville

BOARD NO. 7

Local boards served.—*Dane, Iowa, Grant, Columbia, Sauk, Richland*

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BOARD NO. 8

Local boards served.—*Crawford, Vernon, Juneau, Monroe, La Crosse, Jackson, Trempealeau*

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BOARD NO. 11

Local boards served.—*Polk, Burnett, Washburn, Douglas, Sawyer*

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BOARD NO. 12

Local boards served.—*Bayfield, Ashland, Iron, Vilas, Price*

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BOARD NO. 13

Local boards served.—*Lincoln, Taylor, Clark, Wood, Marathon, Portage*

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BOARD NO. 14

Local boards served.—*Forest, Florence, Oneida, Langlade*

Clarence A. Richards (chairman), Rhinelander; Irving E. Schiek (secretary), Rhinelander; Joseph W. Lambert, Antigo; Alexander F. S. Harter, Rhinelander; Wm. P. Curran, Antigo; Thomas G. Torpy, Minocqua; Ernest G. Ovitz, Laona; and Orville H. Treweek (dentist), Rhinelander

BOARD NO. 15

Local boards served.—*Marinette, Oconto, Brown, Door, Kewaunee*

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BOARD NO. 16

Local boards served.—*Shawano, Waupaca, Outagamie, Calumet, Manitowoc*

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BOARD NO. 17

Local boards served.—*Adams, Waushara, Winnebago, Marquette*

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BOARD NO. 18

Local boards served.—*Green Lake, Dodge, Washington, Sheboygan, Fond du Lac*

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Third district.—*Walworth, Kenosha, Racine, Waukesha, Washington, Ozaukee and Dodge counties:* E. S. Elliott, Fox Lake

Fourth district.—*Rock, Green, Lafayette, Iowa, Adams, Sauk, Columbia, Dane, Grant, Jefferson, and Marquette counties:* James A. Jackson, Madison

Fifth district.—*La Crosse, Monroe, Juneau, Vernon, Crawford and Richland counties:* B. I. Pippin, Richland Center

Sixth district.—*Jackson, Pepin, Trempealeau, Buffalo, Pierce, St. Croix, Dunn, Eau Claire, Chippewa, Barron, Polk, Clark and Rusk counties:* F. E. Butler, Menomonie

Seventh district.—*Douglas, Burnett, Washburn, Bayfield, Sawyer, Ashland, Iron, Price and Vilas counties:* C. J. Smiles, Ashland

Eighth district.—*Oneida, Forest, Langlade, Lincoln, Taylor, Marathon, Wood, Portage, Waupaca, and Shawano counties:* F. H. Kelley, Merrill

Ninth district.—*Door, Kewaunee, Brown, Oconto, Outagamie, Marinette, and Florence counties:* F. C. Huff, Sturgeon Bay

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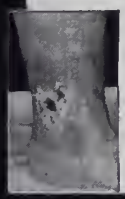

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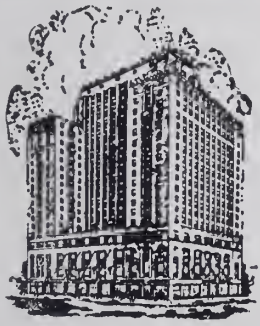

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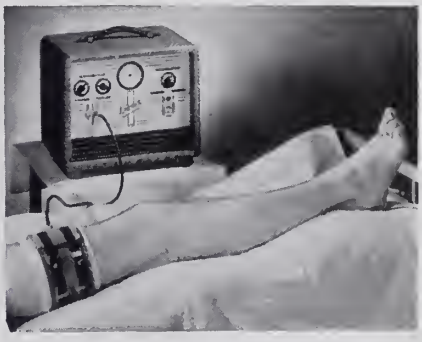

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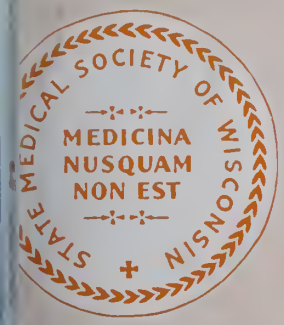

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IN THIS ISSUE

FIVE PAPERS PRESENTED AT POST-GRADUATE INDUSTRIAL MEDICAL AND SURGICAL CLINIC, NOVEMBER, 1942

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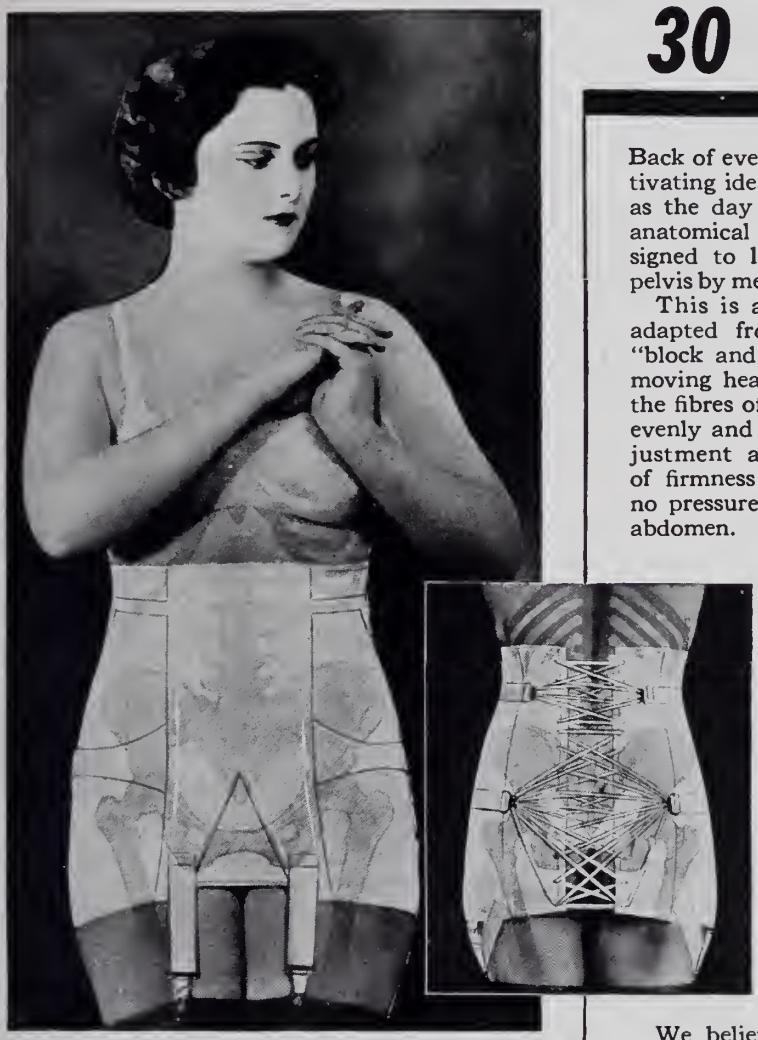

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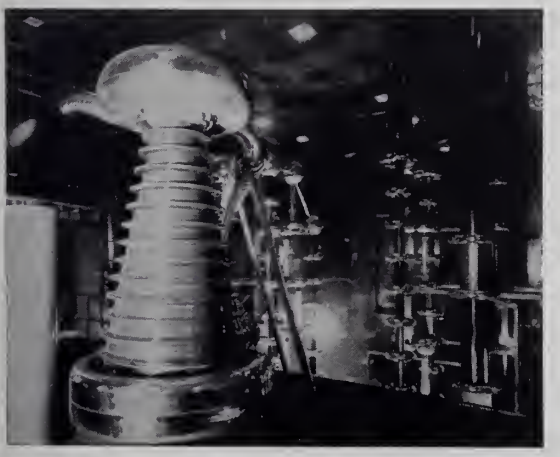

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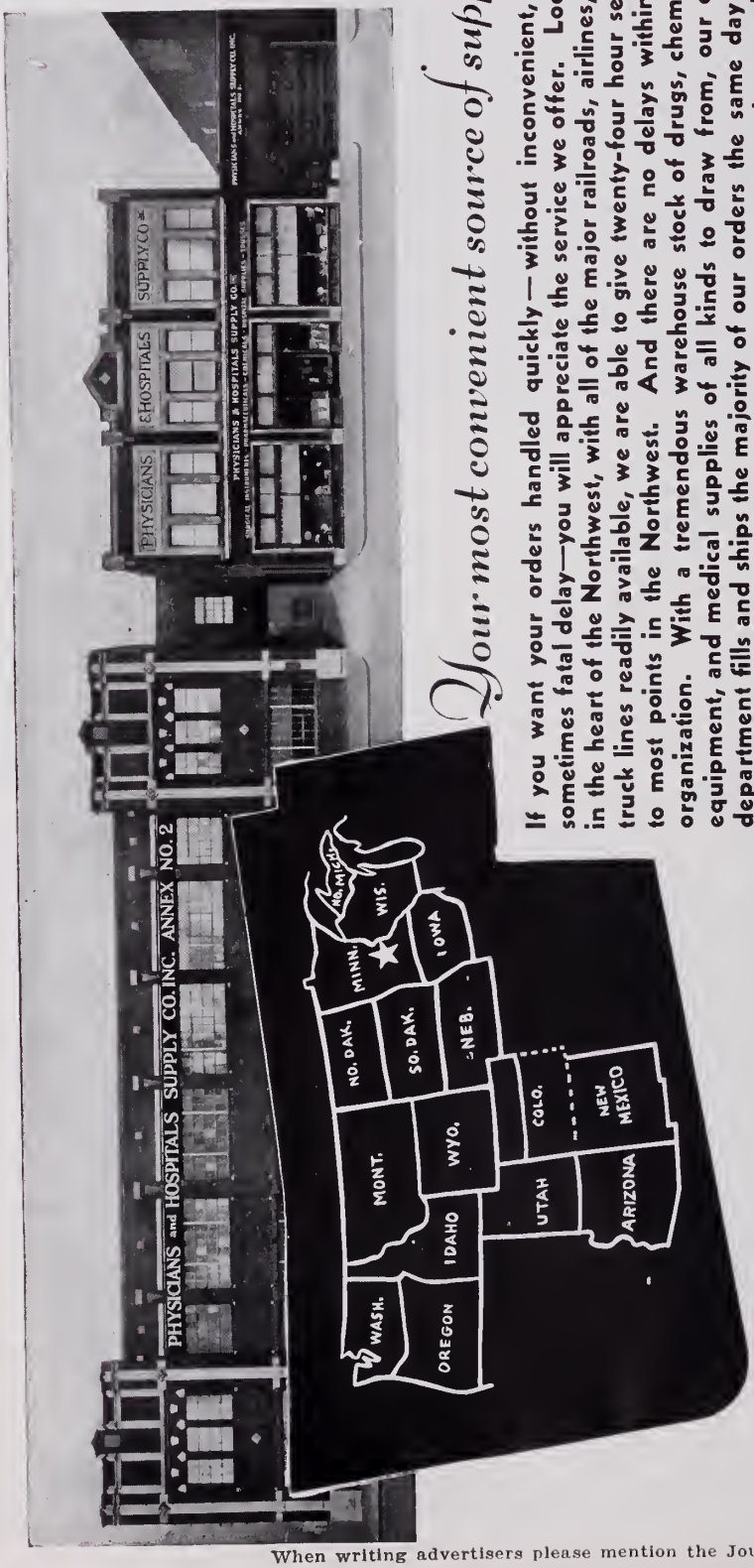

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[1]KOJIS, F. G.: Am. J. Dis. Child. 64:93 (July), 1942; 64:143 (Aug.) 1942.
[2]TOP, F. H., and YOUNG, D. C.: J.A.M.A. 117:2056 (Dec. 13) 1941.
[3]PALMER, L.: Kentucky M. J. 40:254 (July) 1942.
[4]MELNICK, T.: Arch. Pediat. 59:90 (Feb.) 1942.
[5]HOYNE, A. L.: Illinois M. J. 81:12 (Jan.) 1942.
[6]THOMPSON, C. G.: Connecticut M. J. 5:736 (Oct.) 1941.

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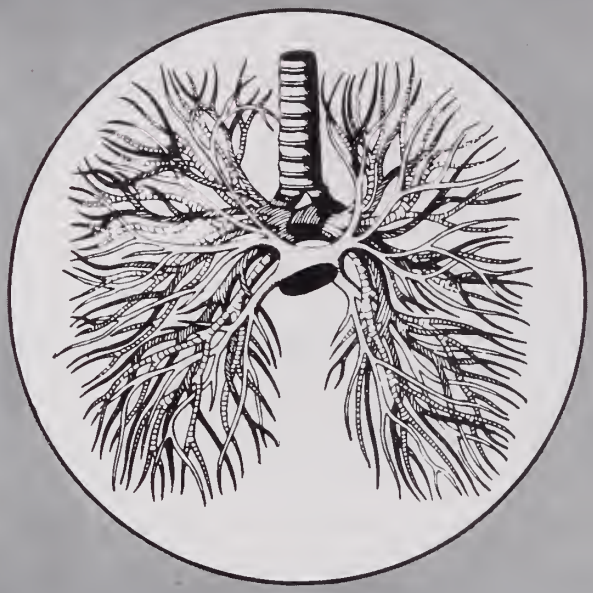

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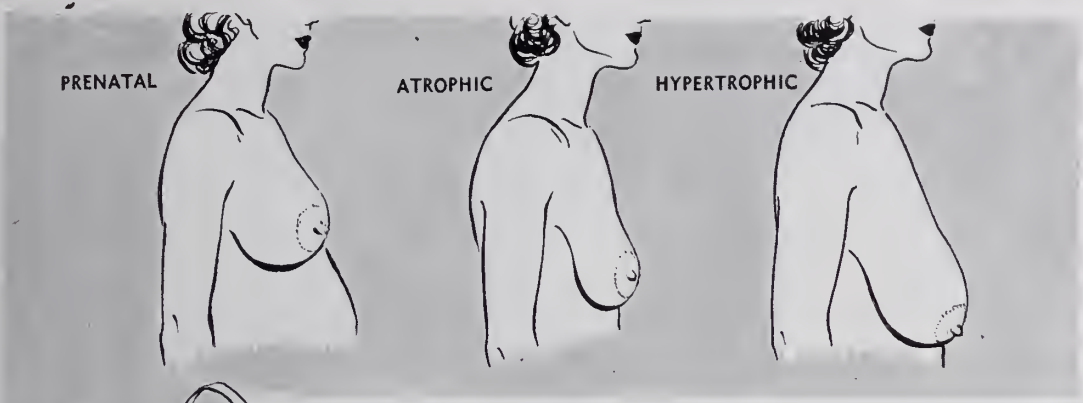

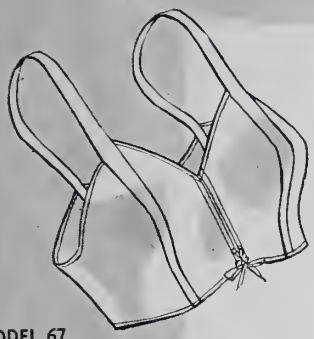

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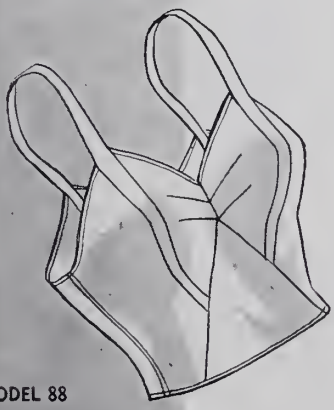
MODEL 64



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Chest Injuries*

By JOSEPH W. GALE, M. D.**
Madison

ANY discussion of body injuries would be incomplete without including those of the thorax. Certainly no other part of the body, except perhaps the skull, contains as many vital structures. The food we eat, the air we breathe, and the blood which circulates in the body are dependent upon the functional integrity of the organs within the thorax. Of these the cardio-respiratory system is the most important, and any alteration in its physiology may produce immediate death. Therefore, this discussion will be concerned primarily with injuries to the cardio-respiratory system.

It would appear advisable to review briefly the anatomy and normal physiology of respiration; thereby obtaining a better understanding of the resultant effects from alterations in the physiologic processes. The thorax is a semirigid cage composed of the spine, ribs, sternum, pleura and diaphragm. Enclosed within it are the lungs, heart, esophagus and other important mediastinal structures. The weakest point in the cage is at its base where protection is afforded only by the thin musculomembranous diaphragm. A second point of weakness is the arc of each rib, since it is at this point that all the force of a blow is transmitted.

Each lung is encased by two serous membranes known as the parietal and visceral pleura. The visceral portion is intimately attached to the lung, whereas the parietal lines the chest wall. Between the two membranes is the pleural space which, under normal conditions, is only a potential one. The lungs are separated by the mediastinum, which is a flexible structure containing the heart, great blood vessels, thoracic duct, esophagus, trachea, and important nerves.

The thorax, through a carefully adjusted and efficient neuromuscular mechanism, is capable of changing its size and shape. It is the change in size of the thoracic cage which produces inflation or deflation of the lungs. In other words, the lungs follow the movements of the thoracic cage.

Normally, a negative pressure exists in each pleural space. This is due to the fact that the lungs, enclosed in an airtight cavity, are smaller in volume than the thoracic cage, but have been inflated to fill the thoracic cavity. Furthermore, the lung is composed of elastic tissue which tends constantly to reduce it to a collapsed state. During rest the amount of negative pressure required to keep the lung expanded is —3.5 to —4.5 cm. of water. During inspiration a sudden enlargement of the thoracic cage increases the negative pressure to —7.5 to —9 cm. of water. The increase in intrapleural negative pressure permits air to enter the tracheobronchial tree. This inspired air supplies the necessary oxygen to the blood. At the same time carbon dioxide is released from the capillaries into the alveoli and expired. Expiration is normally a passive action resulting from the elastic recoil of the thoracic cage and abetted by the inherent elasticity of the lung. It is through these rhythmic movements occurring from sixteen to eighteen times per minute that the necessary chemical exchange takes place between the blood stream and the respiratory tree.

The intrapleural changes also have a direct effect upon the cardiovascular system. Cardiac efficiency is greatly aided by these changes. During inspiration the already

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** At present Lieutenant Colonel, Medical Corps, United States Army.

negative pressure within the vena cava is lowered still further, thus facilitating the movement of blood into the thorax and the filling of the right heart. Studies have shown that one-tenth of the entire blood volume is within the thorax during inspiration, while about one-twelfth is present during expiration.

Flexibility of the mediastinum makes it very vulnerable to changes in intrapleural pressures by producing mediastinal shifting. This may cause periodic obstruction of the vena cava which in turn reduces cardiac intake and output. The flexibility of the mediastinum permits transmission of pressure changes from one lung to the other so that the two lungs really function as a single unit in normal individuals. Thus, it becomes quite clear that any alteration in the intrapleural pressure will be felt immediately through a change in the cardio-respiratory efficiency. Trauma is one of the chief causes of such changes.

Nonpenetrating Wounds of the Chest

Injury may result from direct or tangential forces such as severe blows, squeezing between heavy objects, or falls from great heights. Often very little evidence of external trauma is present, but, as in cranial injuries, the important fact to consider is whether or not there has been damage to the underlying structures. The ribs form the greatest barrier to such injuries and frequently are fractured. If the fractures are limited to one or two ribs without displacement, they will not be serious, although quite painful. Occasionally trauma will be severe enough to produce rib displacement plus pleural and pulmonary pathology.

Penetrating Wounds of the Chest

In civil life most of these occur through the use of sharp cutting instruments such as knives, daggers, ice picks and small firearms. The external wound in these instances is usually small, but again the important factor is the extent of underlying damage. Large extensive penetrating wounds of the thorax may follow explosions or automobile accidents. In these, two added factors must be considered. There may be gross contamination of the wound tract by clothing and dirt, plus the great change in intrapleural pressures which collapses not only the involved lung but also the contralateral one. Hemorrhage may occur with or without penetration.

Blast Wounds

In the present war a type of chest wound which has become known as "blast wound of the lung" has been encountered. It is unusual in that there may be no evidence of an external wound. The explanation is that high explosives set up compression and suction waves which travel for quite a distance, and when they strike a person, molecular changes are produced internally without any apparent effect upon the external surface. These patients may not give any symptoms related to the chest. Examination will reveal an emphysematous chest, impairment in basal resonance, ballooning of the lower chest, and diminished movements of the diaphragm. Autopsy will show blood in the tracheobronchial tree from multiple traumatic hemorrhages in the mucous membrane. Hemorrhages of alveolar and pleural surfaces are present. Microscopic examination reveals generalized arterial dilatation and intense focal capillary dilatation with exudate of fluid into many of the alveoli. If the injury is not severe, the patient recovers in several days.

Cardiac Wounds

The proximity of the heart, pericardium, internal mammary and intercostal vessels to the anterior chest wall makes these structures particularly vulnerable to crushing and penetrating wounds. Industry has recently focused attention upon such injuries and coined the term "traumatic heart" to describe that group of cases where the heart has been subjected to actual external violence. More must be learned through increased experience in order to evaluate properly these cases. The pericardial sac frequently fills with blood or fluid when cardiac damage is present. If such collections continue to increase, the pressure upon the heart will manifest itself by the production of a clinical entity known as "cardiac tamponade."

Foreign bodies within the heart or pericardium may be harmless unless, (1) they compress upon such a physiologic unit as the conduction system or coronaries, (2) foreign bodies may be so large as to interfere with mechanical action of the heart; (3) small foreign bodies in the right ventricle may enter the pulmonary circulation and produce pulmonary infarct. Small foreign bodies in the left ventricle may pass into the systemic circulation, and in these cases they may be removed when they reach a distant organ.

Diagnosis

A complexity of clinical pictures may follow the production of chest wounds. The symptoms and physical findings in both nonpenetrating and penetrating wounds are similar if the deeper structures have been injured. Symptoms may be absent, or they may be of extreme gravity, depending upon the extent and number of organs involved and the complications that develop. The symptoms most frequently complained of are dyspnea, painful breathing, pain along the intercostal nerves, air hunger and occasionally hiccoughs. Hemoptysis is an unreliable sign, frequently appearing late and occasionally not at all.

On physical examination the patient often presents the picture of shock. If an external wound is present, its size should be noted. Sucking wounds should be observed closely and the possibility of pneumothorax considered. The position of apex beat, trachea and presence of tympany or dullness should be followed to determine the presence of pneumothorax, hemothorax or both. On inspiration, there will be a lag of the involved side. The vibratory phenomena will be diminished or absent.

The early complications that may occur are: (1) delayed shock, (2) tension pneumothorax, (3) subcutaneous emphysema, (4) mediastinal emphysema, and (5) extensive changes from large open wounds. A frequent late complication is empyema.

Delayed shock should be eyed with suspicion, because when it occurs we should suspect hidden hemorrhage from the lung or the intercostal and mammary vessels.

All cases of large traumatic pneumothorax should be considered as potential tension pneumothorax. The latter may develop from a wound of the lung or chest wall in which there is a ball valve action allowing ingress but no egress of air from the pleural cavity. The increasing pleural pressure may result in pulmonary and cardiac tamponade of such a degree that function of either is impossible. Roentgenograms and a thoracocentesis with the employment of a water manometer (a method too infrequently used) will yield much valuable information.

The presence of subcutaneous emphysema will confirm the diagnosis of injury to the underlying lung. The extent of the emphysema does not form a useful criterion in determining the amount of underlying damage since a relatively small opening properly placed may permit widespread emphysema while a larger one may confine the escape of air to the pleural cavity. The emphysema may spread widely and occasionally to the point of compressing the trachea and esophagus.

Mediastinal emphysema may follow crushing injuries if the larger bronchi at or near the hilum or trachea have been damaged. The symptoms vary. With a moderate escape of air it appears as a palpable subcutaneous emphysema at the suprasternal notch. In cases where it collects under pressure the emphysema may spread to the neck, head, or over the entire body, resulting in cyanosis and asphyxia. Severe compression of the lungs may produce anoxemia. The diagnosis is based on the presence of subcutaneous emphysema at the suprasternal notch.

Large open wounds inflicted with blunt instruments produce profound shock with rapid loss of body fluids, severe trauma to soft tissues and at times violent hemorrhage.

Injuries to the heart and pericardium should be suspected whenever the triad of symptoms associated with cardiac tamponade develop. They are: (1) low arterial pressure, (2) high venous pressure, and (3) small rapid heart. Precordial distress, dyspnea and pulse acceleration are frequently present with cardiac and pericardial injuries. In rare instances there are no symptoms. A pericardial tap will confirm the diagnosis.

Treatment

The many problems arising in the treatment of chest injuries demand the most acute clinical judgment. All surgeons deriving experiences from the first and present World Wars are agreed on one point; namely, that each case must be individualized and that no routine method of treatment can be instituted.

Wounds involving only the external chest wall require thorough exploration, careful cleansing and closure of the wound. Fractured ribs which are very painful can be handled by chest strapping and medication for pain. However, if the rib fragments are displaced, then the presence of laceration of pleura and lung should be suspected. These cases should be regarded and handled as perforating wounds.

All cases of perforated wounds should be examined immediately to determine the size and degree of contamination, amount of external hemorrhage, position of apex beat, trachea, and the presence of dullness. Packs are placed over the wound to prevent extensive pneumothorax. Shock, which is present in practically all cases, should be treated by the well known routine methods. If there is any degree of contamination of the wound, sulfonamides should be administered in adequate doses. Every case should receive prophylactic doses of antitetanic serum.

In small perforated wounds, if the shock responds to treatment, a policy of conservatism is advisable. In some instances no further therapy is necessary. When at any time evidence appears that the patient's condition is not responding satisfactorily, usually in about two hours, then more radical steps should be taken.

Persistent bleeding may be due to tearing of the lung or injury to the intercostal or mammary vessels. As a rule, laceration of the lung will result in a self-limiting bleeding. This is due to three factors: (1) low arterial pressure in the pulmonary circulation, (2) small bleeding points, (3) collapse of the lung by pneumothorax or hemothorax which helps to control hemorrhage through compression. In view of these factors it appears inadvisable to use early and continued aspiration of blood from the pleural space because further bleeding may be promoted. Aspiration is reserved for that time when the patient's condition is stable and it appears that bleeding has ceased for several hours. At this time aspiration serves two purposes: (1) removes blood which is an excellent culture media for organisms, and (2) aids in rapid expansion of lung with the obliteration of the pleural space. Thus the possible development of a large empyema is minimized.

If the bleeding is not self limited, then exploratory thoracotomy is indicated. It is imperative to determine whether the bleeding is from the intercostal or internal mammary vessels or from one of the larger pulmonary vessels. Details of treatment will be considered more minutely under "large open perforated wounds."

Valvular or tension pneumothorax demands immediate attention, and if the condition is not recognized early, death will inevitably result from the extreme collapse of both lungs and the marked shifting of the mediastinum. If no apparatus is available, a stab wound through the interspace, held open by a tube or other methods, will at times be life saving. Ordinarily a needle can be inserted into the pleural space and connected to a tube, the end of which is placed under water for a depth of 1 cm. and maintained at this level. Immediate decompression is obtained. To insure continued suction the needle must be of sufficient caliber to carry both blood and air. Decompression can best be obtained by a constant negative suction apparatus connected to a manometer, which maintains suction at a desired level permitting early expansion of the lung. After the lung has been expanded for several hours, it can be assumed that adhesions between the visceral and parietal pleura and a sealing off of the leak have taken place. Then the needle should be withdrawn.

The opposite or apparently normal lung must be kept under constant surveillance. Blood or other secretions may be aspirated, producing atelectasis, which may be severe enough to deprive the patient of adequate oxygen supply. Immediate tracheal toilet or bronchoscopy is advisable in these cases. A

clear tracheobronchial tree must be maintained at all times, and during the early critical period intranasal oxygen should be administered.

In perforating wounds, injury to large vessels near the hilum will produce death immediately, or the patient may live for a very short time. Treatment of such cases is of no avail.

Large Open Perforated Wounds

Large, open, perforated wounds produced by explosives and blunt objects are the most serious ones. They are usually associated with extensive trauma, devitalization of lung tissue, severe hemorrhage, large open pneumothorax, rapid loss of body fluids and profound shock. In addition, there is as a rule gross contamination produced by projectiles, clothing or dirt which eventually lead to severe infection. The mortality can only be reduced by immediate radical surgery which eliminates the above factors.

In many of these cases the patient's very poor condition will preclude immediate surgery. Treatment should consist of that for shock and closure of the opening in the chest wall, preferably by application of packs or the use of a rubber dam strapped on three sides with adhesive tape. This allows the air to escape from the pleural cavity, but none can enter. Soon the negative pressure will be reestablished. If packs are used, they should be applied at the end of expiration because in an open pneumothorax air is sucked into the pleural cavity during inspiration and thereby increases the collapse of the lung.

When the patient has responded to the treatment of shock, exploration is performed under anesthesia conducted with controlled respiration. The wound is enlarged and the fractured rib fragments removed. Careful search is made for bleeders in the chest wall and lung. Complete débridement of devitalized chest wall and pulmonary tissue is carried out. The laceration in the lung is controlled by suture or lobectomy. Projectiles are not searched for, but if they present themselves in the operating field they should be removed. All blood clots are removed, sulfonamides applied to the operative field, and the chest wall closed tightly. Before finishing the closure the anesthetist, if possible, completely expands the lung.

Immediately postoperative the temperature rises, the pulse remains rapid and the presence of cyanosis may necessitate oxygen. Coughing, expectoration, frequent changes in position and deep breathing exercises must be encouraged to prevent atelectasis. Sulfonamides should be continued postoperatively in large doses. Transfusions should be given as needed to combat the anemia and low serum proteins. Any accumulation of pleural fluid should be aspirated. If convalescence seems satisfactory and the temperature starts to rise, the burden of proof is upon the surgeon to show that the patient is not developing an infection of the lung or pleural space.

The most frequent late complication following injuries to the lung and pleura is infection. It rarely occurs in the first three days but is common after one week. The high fever frequently noted in the first twenty-four hours should not be interpreted as being due to an infection. This pyrexia rapidly subsides in about twenty-four hours and is due to a combination of factors, including trauma, pleural irritation, hemothorax, etc.

Infections of the pleural space arise from two sources. The organisms present in the tracheobronchial tree gain entrance to the pleural space by way of the lacerated lung. The pleural space may also be infected with organisms brought in with the projectile, clothing and dirt. The type of offending organism is very important. Wounds grossly contaminated with anaerobes carry a more serious prognosis. If the infection is of a simple pyogenic type, the development of empyema can be followed by frequent thoracocenteses and cultures. When frank pus is present, indicating localization of infection, rib resection with open drainage is performed. The usual postoperative care of empyema is carried out. When anaerobes are present, the simple pneumothorax is converted into a pyohemothorax due to gas being liberated by the organisms. This type of infection is treated as any simple one, unless the patient's extremely toxic condition or collapse necessitates closed drainage.

Ordinarily, small infections of the lung will contract and heal promptly under adequate conservative treatment. Large wounds of the lung develop massive areas of gangrene with extensive pulmonary congestion and toxemia. The combination of these factors is overwhelming, and the patient succumbs. Immediate surgery is the only effective method of preventing the development of such an overwhelming infection.

Chylothorax may occur from injury to the thoracic ducts. It is rare and is usually associated with hemothorax. Treatment is similar to that for hemothorax.

In mediastinitis, localization is delayed due to the poor resistance of the tissues. Absorption of toxins liberated by the microorganisms produces a profound toxemia. If the patient is seen early, sulfonamides should be administered immediately and maintained at a high blood level. Many of these will overcome the infection, providing the wound is small. If a large perforation is present, then immediate mediastinotomy together with sulfonamides is indicated.

Cardiac Wounds

In cardiac wounds, cardiac tamponade as revealed by the three cardinal signs: (1) low arterial pressure, (2) high venous pressure, and (3) small rapid heart, must receive prompt treatment. A pericardial tap through the fifth interspace at the left border of the sternum or through the left costal angle will confirm the diagnosis. Immediate surgery should be performed, the pericardium opened, and the laceration of the pericardium or heart should be sutured. If a foreign body is lodged in the heart muscle, conservative therapy is indicated unless there is mechanical interference with the cardiac action. Small missiles in the right ventricle should be removed since they may produce a massive pulmonary infarct. Injury to the conduction system cannot be corrected, and therefore surgery is not indicated.

The successful treatment of chest injuries lies in the correct interpretation of the alterations in physiologic function of the heart and lungs, and the prompt institution of the proper measures necessary for the case at hand.

Eye and Ear Complications of Craniocerebral Injuries*

By WILLIAM E. GROVE, M. D.
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W. E. GROVE

I HAVE been asked to discuss the eye and ear complications of craniocerebral injuries. By craniocerebral injury I mean any trauma to the head, with or without skull fracture, of sufficient force to derange the function of the brain in any way. This derangement of brain function is entirely independent of the question of skull fracture and can occur as readily without fracture as it does when the skull is actually fractured. Nor is a period of unconsciousness a necessary prerequisite for the production of brain damage after trauma to the head. A prolonged period of unconsciousness and demonstrable skull fractures only indicate, in a general way, the severity of the trauma. They are not reliable factors for deducing the kind and amount of damaged brain function. A careful functional study of all of the cranial nerves, together with a general neurologic examination of the injured, is of vital importance in evaluating the amount of damage the brain has suffered. I have selected the second, third, fourth, sixth, seventh and eighth cranial nerves for this brief survey because they are the most frequently involved in trauma to the head.

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Eyes

Discoloration and suggillation about the eyes and at the root of the nose, especially when associated with nasal bleeding, in the absence of any evidence of direct trauma to the forehead, nose, and cheek, may have no significance in the production of any eye symptoms, but are indications of a fracture of the anterior cranial fossa. A loss of the sense of smell, indicating damage to the olfactory nerve or bulb, is often associated with this type of injury.

A dilated pupil, either fixed or reacting to light, is evidence of some intracranial lesion which interrupts the reflex arc. This lesion, usually hemorrhage, is in the brain stem, near the nucleus of the third cranial nerve. In examining for unequal pupils, one must be sure that the light strikes both eyes equally, and the examination should be made in both bright and subdued lights. When the pupils are equal, but one reacts actively and the other sluggishly, one can make the same deduction as from unequal pupils. One must, however, exclude any other factors which could produce these aberrations.

Paresis or paralysis of one or more extraocular muscles producing an actual or unnoticed diplopia are of fairly frequent occurrence. By unnoticed diplopia I mean one of which the patient is not conscious until the action of the extraocular muscles is carefully studied. Any of the extraocular muscles may be involved in a paresis, but the superior oblique is more frequently involved than the others. These lesions are due to hemorrhage in the brain stem. A sixth nerve paralysis may result from a basal skull fracture, crossing the tip of the petrous pyramid, and the third and fourth nerves may be paralyzed by an anterior fossa fracture involving the posterior portion of the orbit. Ptosis, caused by a paresis of the third nerve, can occur, but is not frequently observed.

I am often asked to check the eye grounds of a patient who has recently suffered head trauma. In the majority of cases this is unnecessary. Elevation of the optic disc or blurring of its margins are indicative of an increased intracranial tension which has operated for a relatively long period of time. A rapid increase of intracranial pressure kills the patient long before optic disc changes are demonstrable. The increased pressure must operate for a long time before fundus changes can be demonstrated.

Loss of accommodation is a frequently encountered symptom. It is characterized, not so much by an actual inability to see at the near point, as by the inability of sustained near effort. The loss of accommodation can easily be measured by the Prince rule in young individuals and by the increased amount of spherical correction necessary for near vision in the presbyope.

Actual decrease in the acuity of vision up to the point of blindness due to hemorrhage into the sheath of the optic nerve or to an interruption of the continuity of the nerve by a fracture line is occasionally encountered, but is a relatively rare finding.

Constriction of the peripheral field of vision is occasionally encountered, but is difficult to evaluate on the basis of traumatic pathology. A loss of peripheral field, not associated with any loss of visual acuity and independent of central or paracentral scotomata, must be viewed with suspicion on the basis of head trauma. A quadrant field defect is evidence of a large lesion in the temporal lobe.

In my opinion, a study of the color fields is of no particular value in evaluating posttraumatic brain conditions.

Ears

Of all the cranial nerves the eighth is the most vulnerable to head trauma, either with or without skull fracture. Cranial nerves are susceptible to damage from head injuries in inverse proportion to their length. The eighth nerve, pursuing a very short course from its exit from the brain and its entrance into the internal auditory meatus, is peculiarly susceptible to traction from the movement of the brain within the skull at the moment of impact.

Again, blows and jarring of the head, insufficient to fracture the skull or even to cause unconsciousness, can and do produce hemorrhages in the basal coil of the cochlea, in the neighborhood of the round window.

This same type of injury can also produce petechial hemorrhages and localized loss of vasomotor control in and around the vestibular nuclei at the floor of the fourth ventricle. Naturally this type of pathology is more likely to occur in the more severe forms of head injury which are associated with fracture and loss of consciousness.

Furthermore, in addition to these nonfracture producing head injuries, the base of the skull may be fractured by force applied to any portion of the vault or face or transmitted to it by the jar of the vertebral column. Basal skull fractures very frequently involve the middle fossa, less frequently the anterior fossa, and least frequently the posterior fossa. Because of the complexity of the base of the skull, fractures of the anterior and middle fossae are hard to visualize on the roentgenogram, whereas those of the posterior fossa which cross the petrous pyramid can always be so delineated.

In examining a head injury case for evidence of ear pathology, the following points should be kept in mind: bleeding from the ear or the escape of cerebrospinal fluid; hematotympanum; fractures of the external auditory canal; suggillation or discoloration over the body of the mastoid, occurring on the third or fourth day; the presence or absence of hearing shortly after injury; the complaint of vertigo, especially of a rotatory type; the presence of a spontaneous nystagmus; the presence or absence of any sign of facial paralysis.

Bleeding from the ear, the escape of cerebrospinal fluid, or the presence of a hematotympanum are caused by a fracture running along the anterior border of the petrous pyramid and projecting itself into or through the middle ear. These signs may occur early or be delayed for a week or two. They are definite evidence of a so-called longitudinal fracture.

If there is any discharge of blood or spinal fluid from the ear, an otoscopic examination should not be made even by an otologist because of the danger of introducing infection and setting up a meningitis. The ear should be covered by sterile dressing and a "noli-me-tangere" sign put up. With these precautions the prognosis as to life is relatively good if any hearing is present in the ear or ears, but must be guarded if all hearing is gone because, if this is true, the longitudinal fracture has been complicated by one crossing the pyramid and opening the labyrinthine capsule. If there is no discharge of blood or spinal fluid, an otoscopic examination should be made to look for signs of hematotympanum or external canal wall fractures.

A discoloration or suggillation over the surface of the mastoid which is first seen three or four days after injury, the so-called Battle's sign, is indicative of a fracture of the mastoid process. It may or may not be associated with other fractures of the temporal bone. One should be careful to differentiate this sign from a hematoma in the same region which is seen shortly after the injury and is due to bruising of the soft tissues.

Loss of Hearing

Immediately after a head injury of sufficient force to produce unconsciousness or a typical postconcussional syndrome, the hearing is obtunded until the sensorium clears. After consciousness has returned and the period of shock is over, the hearing should be roughly tested by voice or whisper, even in those ears which are bleeding or discharging cerebrospinal fluid. Total loss of hearing is strongly indicative of a posterior fossa fracture which has crossed the petrous pyramid and destroyed the cochlear contents. This is usually associated with a violent vertigo, which persists for several weeks. In other cases of head trauma exhibiting vault fractures, longitudinal fractures of the temporal bone and even in those with no demonstrable fracture, the hearing is frequently damaged by hemorrhages into the basal coil of the cochlea. These hearing losses are of the perceptive type of deafness and involve the high tones. If the longitudinal fracture line crosses through the middle ear, dislocates the ossicles and causes adhesive processes during healing, a conductive type of deafness may be superimposed upon the perceptive type, and the audiometer examination may show loss for all tones. This is also true if the bleeding ear infects, and an otitis media or mastoiditis ensues.

While we may encounter a vestibular disturbance without associated loss of hearing, the reverse is rarely if ever true. Where the hearing is damaged by the head injury, the lesion must occur in the temporal bone where the cochlea is closely associated with the peripheral vestibular mechanism. When a hearing loss occurs under such circumstances, it is almost always associated with some symptom or sign of vestibular disturbance. It is almost inconceivable that the trauma would affect the cochlea and completely spare the vestibule and semicircular canals. Therefore, if a patient complains of traumatic loss of hearing and presents no sign or symptom of vestibular trouble, such loss of hearing must have antedated the accident, or the individual's veracity is subject to suspicion. Because of the wide distribution of the hearing center and its bilateral representation in the brain, it is extremely difficult to envision a loss of hearing due to trauma in the central nervous system.

On the other hand, the vestibular apparatus may be traumatized without any associated loss of hearing. This can be caused by petechial hemorrhages in the rather compact central vestibular nuclear area, just under the floor of the fourth ventricle.

Postconcussional Symptoms

Headaches and dizziness are the commonest of the postconcussional symptoms. Headache is a subjective symptom, not amenable to objective proof. Dizziness, however, if due to injury to the central or peripheral vestibular mechanism, is amenable to such proof. The commonest form described is that in which the individual experiences a sense of rotation either in himself or in objects in the vicinity. This type of dizziness is called vertigo. It is always due to a disturbance in the vestibular mechanism. Other types of dizziness, such as a swaying, an unsteadiness, tipping or tilting of objects, or things going black before the eyes, may or may not be due to actual vestibular damage. They are due to a vestibular lesion, if they are associated with the spontaneous signs of vestibular disturbance, with a hyperirritable response of the labyrinth to minimal cold water stimulation or an unequal response of the two vestibular mechanisms to equal minimal cold water stimulation. The spontaneous signs of vestibular disturbance are a rotary-horizontal nystagmus, a past pointing, a drift in the deviation test, a positive Romberg reaction, poor girdle reactions or a gait deviation.

Sometimes one, sometimes another, but never all of these spontaneous signs are found at the same time. Nor are they always found on every examination. When they are due to a direct lesion in the labyrinth, they will be constant and continuous for the first two or three weeks and will then tend to subside along with the vertigo as the two labyrinths tend to stabilize.

Not so when the lesion causing them is in the central nervous system. In this case the attacks of vertigo are of short duration and are brought on by sudden movements of the head, by stooping, by lifting, by elevation above ground level, by exposure to sun and heat, and by indulgence in even small quantities of alcohol. As with the vertigo, so also the spontaneous signs of vestibular disturbance may be present at only such times as there are vasomotor disturbances in the central nuclear area of the vestibular nerve. For this reason they cannot be elicited on every examination. For this reason also it is sometimes necessary to examine the individual after rapid shaking movements of the head, which tend to simulate those voluntary movements of the patient's head which can bring on the localized vasomotor disturbance and its associated signs and symptoms.

Age a Factor in Recovery

As long as the spontaneous signs above mentioned can be elicited and as long as the minimal caloric tests indicate a vestibular disturbance, so long can the patient's subjective complaint of vertigo be substantiated. However, it must be said that in the course of time these attacks of vertigo become fewer and less severe. It must also be stated that age is a great factor in the recovery of a vestibular balance. The younger the patient the better are his chances for a complete recovery.

Handicaps of Hernia in Industry*

By RAYMOND W. McNEALY, M. D.
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HERNIAS are common ailments, and they are probably increasing in frequency. One seldom gives serious consideration to this fact because of the benign character of the condition. If we were to accept the statement of a distinguished anthropologist, who wrote as follows: "With the development of urban civilization and industry, physical deterioration becomes appallingly common . . . every sort of physical abnormality is increasingly prevalent," we would probably pay little heed because there is little or nothing to be done about it. It is evident that urban civilization and industry gain momentum with each decade, but why physical deterioration should become so appallingly common leaves us without an answer.

The handicap of hernia in industry is apparent in the annual report on industrial accidents in Illinois, which shows that in 1941 there were 1,515 cases handled by the industrial boards. There was paid on these $211,441, and they necessitated 15,452 weeks of disability.

Some further idea of the incidence of hernias can be had from figures furnished by the selective service examination boards. In 1917 and 1918, out of more than 2,000,000 men examined for the draft, 4 per cent showed either hernias or enlarged inguinal rings. Among the present draftees, 1.8 per cent of the 1,000,000 men so far examined have been rejected because of the presence of hernias.

The somewhat lower percentage of hernias in the men now being called for army duty is not a reliable measure of the actual number of such defects in the entire population. The draftees are young men. Hernias show a marked tendency to increase in frequency with age, and the lengthening of the average life cycle has resulted in an increased number of older persons in our population. We must infer, therefore, that in a study including all age groups a higher percentage of hernias would be found than that expressed in the figures from selective service examinations.

The handicap of hernia to industry not only results from the frequency of the condition but from the fact that it is difficult to establish equitably the responsibility for the care and treatment of this condition and arrange compensation during the period of disability. The occurrence of an increasing physical deterioration which sooner or later becomes an obvious disabling ailment is unusually hard to classify as an accident. This problem sets up something for the legal profession to worry over and relieves us of some responsibility.

Several progressive steps have helped to solve the hernia problem in industry. Of first importance among these is the routine preliminary examination of all employees. The supplementary periodic examination should uncover defects missed at the initial examination. A helpful legal restriction is the one which made void the signing of waivers of the right of employees to make claims for hernias which were present when they went to work. The idea here was to relieve the employer of responsibility for a condition which the employee knew he had and which the employer recognized as a potential danger but from which the employer was secured from loss by the employee's signing a statement to the effect that he would not make any claim should

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anything develop out of this specific condition.

The most embarrassing single question to employee and employer has been the question of the so-called "accidental" or "traumatic" hernia. In this field there is room for honest difference of opinion and far too much room for humbug. What part accident plays in the development of a hernia would start no end of discussion and would probably end in few valid conclusions.

The majority of hernias which occur in industry are of the inguinal variety. This statement should be supplemented at once by the explanation that under this simple heading of inguinal hernia we include two very distinct types of hernia. They usually appear as one or the other variety, but both may be present in the same side in the same individual and develop concurrently.

Indirect Inguinal Hernia

The indirect inguinal hernia can be regarded as a condition predicated more definitely on lines of physical development or failure of development. The evolutional changes of this part of the human anatomy offer opportunity for interruptions and failures of complete transformation. There is no way to estimate accurately how much of the tendency to hernia is dependent on inherent weakness and how much is dependent on accidental overload or strain. Much stress has been laid on the presence of a preformed sac. Every male who has testicles in his scrotum has a preformed peritoneal sac in his inguinal region. That these sacs have undergone some change and exist as the definitive infundibulum, ligamentum vaginale, and tunica vaginalis testis does not alter the fact that they represent the original peritoneal sac which accompanied the testicle as it left the abdominal cavity to take up residence in the scrotum. How completely the original sac follows the lines of complete development is difficult to estimate in any case. How much stress or strain is necessary to open up, expand or pull out additional peritoneum in a given case is likewise quite impossible to estimate.

Direct Hernia

It might seem that the indirect inguinal hernia presented unusual difficulties, and that in the direct hernia it would be much easier to decide what part of this condition depended on physical deterioration and what part depended on accidental injury or strain. This direct type of hernia offers almost as much difficulty of interpretation as does the indirect hernia. The direct hernia appears in a location where there is no congenital precursor of its peritoneal sac. The hernial opening in the endo-abdominal or transversalis fascia has no embryonal anlage. The fact that it is stretched and thinned before it becomes an actual opening further confuses the question. A simple analogy would be that the hernia occurs like the wearing out of the seat of a man's trousers. It becomes threadbare and distressingly thin before a hole actually appears. If one is discussing the appearance of the hole through which something comes as a hernia, then the stretching is something that is related to but is not actually the real producer of the hernia. The hole occurs when a break in the continuity of the fibers actually occurs. This final step may definitely be caused by an accidental trauma or strain.

Up to now I have indulged in the theory of hernia, but the repair of hernias is of greater interest to the patient and to the employer. In the repair of the indirect hernia the problem concerns itself with interruptions of developmental function which lend themselves in most instances to satisfactory repair. There is every reason to expect few recurrences when operations are done for indirect inguinal hernias.

On the contrary, in an attempt to repair a direct hernia you face a far more difficult problem. One usually has a sac which is much more difficult to manage. It offers far greater hazards, and the neck of the sac is usually very broad. The structural breakdown which gives rise to the defect in the fascia offers the same difficulties that the tailor finds in repairing a hole in the seat of a threadbare pair of trousers. One has not only the hole to repair, but the material all about the hole is stretched and thinned to a

point where it lends itself very poorly to a lasting repair.

In reconstructing the architecture of the lower abdomen, one runs into innumerable difficulties. It is apparent that the abdominal wall resembles very closely in general architecture an automobile tire. Visualize, if you can, an old tire whose inner tube has deteriorated, whose fabric has lost its strength and whose rubber has lost its elasticity. Then you can appreciate what difficulties are encountered in repairing direct hernias. Direct hernias occur frequently in persons past middle life. Their tissues are, to say the least, not strong. Fascial planes are stretched and thinned, and muscles have become less efficient than they formerly were. To use this material and expect it to hold up under hard wear is not more reasonable than to expect good service from patched old tires.

Much enthusiasm has been displayed in recent years for the use of autogenous grafts. The difficulties surrounding the removal and reintroduction of these grafts into new locations make any operation of this kind a difficult technical procedure. The introduction of old fascia into new locations cannot be expected to contribute a great deal. It is pleasant to record that the use of autogenous fascia in the repair of hernia was first described by the late Dr. McArthur of Chicago. He described this method in 1901, and it lapsed into disuse only to be brought into increased popularity in the last few years.

One should not conclude a discussion on the handicapping hernia without mentioning something about the injection treatment. Another era of enthusiasm for injection is just quieting down. During the last five years certain members of the profession have rejuvenated this early method of treatment until it has attained a considerable vogue. Its rather extensive use has yielded but few crumbs of comfort for its sponsors. It has been found to be serviceable in only a limited number of cases, and when it has been employed without a careful selection of patients, the very high percentage of failures has aroused a skepticism of its usefulness that is fully warranted. The most that can be said for the injection treatment of hernia is that its field is limited and its permanent successes are few.

In conclusion, I would like to stress the importance of reapplying ourselves to the very important problems found in the appearance of hernias in people who are employed in industry. Most surgeons might well spend some time in reviewing the embryology and anatomy of the inguinal region.

I, personally, am left without any recommendation to make as to how we might change the appalling tendency to general physical deterioration. I am willing to turn this problem over to the most optimistic teachers of genetics and eugenics.

TUBERCULOSIS IN THE AGED

That pulmonary tuberculosis is not uncommon in elderly persons is a fact that seems to fail to impress both the public and the physician, possibly due to the nature of the older body affected by a chronically progressive disease. Those who have studied pulmonary tuberculosis in the higher age groups are impressed with the lack of emphasis on this phase in the study of the disease. A flank attack on this weak spot would circumvent more circuitous methods to the same end, namely, the lessening of the general incidence of tuberculosis. Freeman, J. T., and Heiken, C. A.: Am. J. M. Sc. (July) 1941.

Common Fractures and Their Treatment*

By HERMAN C. SCHUMM, M. D.
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ON REVIEWING the recent report of the Industrial Commission of Wisconsin on the disabilities in workmen's compensation cases settled in 1941, I was much impressed by the scope of the report and its value to us physicians as a guide for improving our care of the injured.

Out of a total of 23,755 cases settled, 4,146 were fractures, which resulted in 467,035 working days lost. The sum of $920,372 was paid to the patients as indemnity, and $350,224 was paid for the medical fees. The number of days lost is certainly a challenge to those of the medical profession interested in the care of fractures.

In a further breakdown of the 4,146 fracture cases, twenty-eight, or 1.48 per cent, died or were totally disabled; 553, or 7.47 per cent, resulted in a permanent partial disability; and 3,563, or 91 per cent, recovered without any permanent disability. In reviewing my own fracture cases, I am definitely of the opinion that the percentage of recovery, without disability, is somewhat high.

Those fractures that come under a permanent partial disability are of special interest to us, as they make up less than 8 per cent of the fracture total, but they account for more than a third of the working days lost and at least half of the indemnity paid.

The three most common sites of fracture in the 542 cases rated, relative to major scheduled injuries, for the years 1940 and 1941 were: (1) fractures of the ankle, 143 cases, or 28.2 per cent with an average of 328 days lost; (2) fractures of the wrist, 84 cases, or 15.1 per cent, with an average of 382 days lost; (3) fractures of the elbow, 62 cases, or 11.4 per cent, with an average of 626 days lost. These three sites accounted for 54.7 per cent of all fractures resulting in permanent partial disability, under the major schedule.

As one glances over this list he can not help being impressed by the fact that all three locations cited are at joints. The function of joints is mobility. Hence, any interference of function results in a disturbance of the normal mobility, which means disability. Every fracture into a joint is a potential cause of arthritis, and arthritis usually means pain. Therefore, the treatment of fractures into joints, and especially those in which joint surfaces themselves are involved, requires a much finer nicety of reduction than does the treatment of fractures of shafts of long bones. The reduction should be made early. If manipulation fails to give satisfactory reduction, then an early resort to operative measures, that is, within the first five to seven days, is in order. Severe shock, or a poor general physical condition, is the only real contraindication to operation. Late operative procedures, while often improving the condition, as a rule do not give the results one can expect with early operative reduction.

The earlier one can institute active motion in a joint, or even in adjacent joints, the better the end results. One should always keep in mind, however, that too early motion may lead to displacement of the fragments. The prevention of the latter requires judgment, experience, and frequent, careful observation, both physical and roentgenologic.

I. FRACTURES OF THE ANKLE JOINT

Fractures of the ankle joint are apparently just as frequent in industry as in everyday life. The end results are the same. As a rule, the statistical study of the end results in private cases is not as complete as those in industrial cases.

Fractures of the ankle joint may include the tibia, the fibula, the astragalus, or combinations of any of these bones. Fractures in which the estragalus is involved are comparatively rare and, for the sake of time, will be omitted from this discussion.

Many of the fractures involving one or the other of the malleoli, or combinations of the two, can easily be reduced by closed manipu-

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lation. A snug-fitting plaster cast, extending from the toes to the knee, affords sufficient immobilization. Remember that the astragalus and foot are most firmly attached to the outer malleolus, and that when there is any displacement they displace together. Usually, in manipulations of an ordinary ankle fracture, if the foot is brought into supination and at a right angle to the leg, with pressure applied medially on the foot, the fragments come into their closest approximation. In the simpler fractures of the medial malleolus, or of the posterior lip of the tibia, it has been my experience that a lack of sufficient dorsal flexion has accounted for the failure to get a satisfactory reduction.

In a recent review of all of the fractures of the ankle which I have seen, the outstanding cause of disability was a traumatic arthritis occurring in those cases where there had been a tear of the lower tibiofibular ligament, with consequent separation at the lower tibiofibular joint. Here, either through failure to get a satisfactory reduction, or through failure to maintain reduction sufficiently long for a firm union to occur, a separation followed permitting the astragalus to slide laterally on the tibia.

This causes a slight varus, and if weight is borne on the foot, the lateral weight bearing surface of the lower end of the tibia wears out the cartilage in the middle of the weight bearing surface of the astragalus. Pain then develops. If this condition goes on for more than a few weeks, the end result at its best will be an arthrodesis of the ankle joint, without pain.

The best prevention is early recognition of the separation and maintaining accurate reduction. It may even be necessary to resort to an open operation. Apposition may have to be maintained by metal screws or nails, plus immobilization with a plaster walking cast for a period of at least eight weeks.

One other source of trouble in ankle fractures is a fracture of the posterior lip of the tibia. Fractures of this lip, if sufficiently posterior, as a rule cause no trouble. If the fracture line is far enough anterior, so that it comes at a point where weight bearing is important, and if the fragments are not accurately replaced by open operation and held in place by means of metal fixation, as necessary, traumatic arthritis is very likely to occur.

The use of the walking cast in all possible cases of ankle fracture is of material aid in cutting down the period of convalescence. Weight can be borne as soon as the patient feels able. This is usually between the fourth and seventh day. If the cast is worn for a period of six to ten weeks, and the patient is faithful in bearing weight on the cast, there is usually very little swelling or stiffness when the cast is removed.

II. FRACTURES OF THE WRIST

If there is any truth in the old saying that familiarity breeds contempt, it is borne out by the end results in fractures of the wrist. In this particular schedule, there were 84 cases with an average of 382 days lost. Under the most skillful handling, the average Colles' fracture (and this is probably the easiest type of wrist fracture to treat) ends with a permanent disability of 5 per cent at the wrist joint. Then one wonders why this fracture is considered and treated so lightly by the profession at large.

The essential points to keep in mind when treating fractures of the wrist are: (1) the tip of the styloid of the ulna projects at least one-half inch distal to the styloid of the radius; (2) the joint line is at an angle of 120-degrees to the long axis of the radius; that is, the dorsal surface of the distal end of the radius is distal to the palmar surface; (3) the distal end of the ulna should maintain its normal relationship to the distal end of the radius and not project distally to it; (4) the question of fracture or dislocation of any of the carpal bones is best determined by A. P. and lateral views of both wrists taken in similar positions.

Most fractures of the wrist can be fairly satisfactorily reduced by traction and manipulation. In those cases where there is an impaction of the fragments of the radius, the impaction is usually on the dorsal aspect, resulting in a loss of the normal angle of the joint line. This impaction causes some disturbance in the relationship of the ulna and

radius at the lower radio-ulnar joint. When present, this impaction is broken up by first increasing the deformity under anesthesia, preferably the injection of 1 per cent novocain locally, or pentothal sodium intravenously. The wrist is flexed palmward, with the wrist in ulnar deviation and the forearm in moderate pronation. If the fragments appear to maintain their position satisfactorily in this position, a light plaster cast is then applied extending from the metacarpophalangeal joint line to above the elbow joint. The extension above the elbow joint is important in maintaining pronation. In those cases where position alone is insufficient to maintain the relationship of the fragments, traction is a necessary addition to the above treatment. This is most satisfactorily done by inserting a Kirschner wire through the distal ends of the second and third metacarpal bones and a second Kirschner wire through the proximal end of the ulna, incorporating the wires in the cast extending from the metacarpal heads to below the elbow.

It is my opinion that the failure to recognize those cases where traction is necessary, and then to apply it, is one of the more important factors in the resulting disability. In cases of fracture of one or more of the carpal bones, the treatment of choice is the application of a cast from the metacarpophalangeal joints to below the elbow joint, with the wrist in dorsal flexion of 40 degrees and radial deviation.

In all instances, early motion of the fingers and shoulder is essential. In fractures of the carpal bones, the cast should be maintained eight weeks. In fractures of the radius or ulna, if under careful observation, the cast can be removed in from three to six weeks and physiotherapy and hydrotherapy instituted.

III. FRACTURES OF THE ELBOW

The schedule lists 62 cases averaging 626 working days lost, over two years. This is a real challenge to us all. I wonder if our new motto, "Too little, too late," applies here; or do we do too much at the wrong time?

Fractures of the elbow consist of fractures of the outer or medial condyles of the humerus, the olecranon, or coronoid process of the ulna, or the head of the radius, or any combination of these bones.

Most of the fractures involving the humeral condyles can be satisfactorily reduced by making traction on the forearm and then manipulating. The position of choice for maintaining the fragments is acute flexion. The use of the Jones collar and cuff is sufficient to maintain the degree of flexion. When the joint surface of the condyles is involved, open operation is often indicated, and fixation of the fragments with metal nails, or screws, is sometimes necessary.

When traction is necessary it is most efficiently applied by inserting a Kirschner wire through the upper end of the ulna and holding the forearm at right angles to the arm, then making a pull in the line of the humerus. Fractures of the coronoid process of the ulna are best treated by flexing the elbow acutely and establishing fixation with a Jones collar and cuff.

Fractures of the olecranon, either comminuted or with widely separated fragments, are best handled by open operation. The torn portions of the triceps insertion are sutured with catgut, which holds the fragments together. Insertion of a nail, or a spike, through the end of the proximal fragment down into the medullar cavity prevents backward and, what is more important, radial bowing at the site of fracture. Following an open reduction, a cast is applied and kept on for the first two weeks. With a spike in place, active motion can be started at the end of two or three weeks.

Fractures of the head of the radius probably offer as great a problem to treat as any injury in the elbow joint. Simple, linear fractures through the head should always be treated conservatively. Simple flexion of the elbow and maintenance of this position for a week, or until pain subsides, is usually sufficient. Comminuted fractures, or a definite displacement of a single fracture, indicate the necessity of the removal of the entire end, the head being resected below the orbicular ligament. If the head of the radius is

removed, the earlier it is done, the better. After three days the period of optimum benefit has passed.

The most common complications of fractures about the elbow are myositis ossificans and injuries to the ulnar, or median nerves. A myositis ossificans is likely to develop about the attachments, or along the course of any torn muscle or ligament. This can best be prevented by early, complete reduction of all fractures followed by adequate fixation in those cases in which it is suspected that a myositis ossificans may occur, or after it is seen to occur. Rest and heat is the best treatment when this takes place.

Early, active motion is indicated in the average elbow case. Passive manipulation is contraindicated. It does more harm than good. In my experience, it has done more to delay the return of normal motion than any other one thing.

Summary of the Successful Treatment of Fractures Into Joints

1. Early, accurate reduction of the fracture. If closed manipulations do not produce a good reduction within forty-eight hours, open reduction is indicated.

2. Adequate fixation of the fragments. A well moulded, nonpadded cast, traction, or skeletal fixation may be the method of choice.

3. Early, active motion. The patient can do far more for himself, after removal of fixation apparatus, by daily, active exercises than the best physiotherapist can with passive exercises.

4. In serious, comminuted fractures, where chances of motion are small, early arthodesis of joints in the position of election will cut down the period of convalescence and the amount of disability. This is particularly true of weight bearing joints.

Reduction of Disability in Fracture Management*

By CHESTER C. SCHNEIDER, M. D.
Milwaukee

C. C. SCHNEIDER

THE necessity of good fracture management is more important today than at any time in the history of our country. Industrial and automobile accidents constitute two of the major causes of reduced effectiveness in our all out effort to succeed in the present global conflict. Economic pressure today demands adequate care of the injured, and the criteria by which the results of their care are evaluated are concerned as much with time and money as they are with appearance and function. The treatment of fractures today requires the doctor to be a combination of surgeon and orthopedist with a complete appreciation of physiologic mechanics so that all the methods and devices of modern therapeutics are at his command. Because the general practitioner will no doubt care for the majority of fractures, he must learn to treat adequately those cases which he is capable of handling and recognize those which are beyond his capabilities when he first sees them, rather than after he has proved his insufficiency through failure. In the management of fractures, it is paramount that a consistent line of treatment be provided in each case and followed through, doing everything at the right time, the right place, and in the right sequence.

The reduction of disability in fracture management requires the doctor to recognize that the injury is never limited to the bone alone, but that the primary traumatizing force usually extends to all the overlying soft tissues including blood and lymph vessels as well as muscles, ligaments, and nerves. Subsequent swelling, hemorrhage, and disuse

* Presented before the Postgraduate Industrial Medical and Surgical Clinic of the State Medical Society of Wisconsin, Milwaukee, November, 1942.

may further affect these tissues leading to important influences which cannot be disregarded in achieving a complete recovery from the injury. For this reason, the method of treatment employed must encompass all the aspects of the injury and its subsequent reactions and must overcome all their effects before maximum recovery can be achieved.

All fractures should be reduced as soon as possible after their occurrence because the sooner the reduction has been accomplished, the sooner will healing proceed, the smoother will be the convalescence, and the better the result. It is a serious but frequent error to "wait until the swelling subsides." Swelling that accompanies fractures results from leakage of blood from the fractured bone ends, from added trauma that follows movement of the unreduced fragments, from infiltration of white blood cells and edema, and from distorted blood vessels due to malposed fragments. Prompt and accurate apposition of the fractured bone ends, followed by careful and complete immobilization, will check the hemorrhage, relax muscle spasm, and thus relieve pain and swelling. Even when considerable swelling is already present after a delay of several hours or days, the best way to make it subside is to perform a reduction at once, carefully immobilize the part, and keep it elevated. If reduction of fractures of shafts of long bones is delayed, the interposed clot becomes firm after a day or two and interferes with satisfactory replacement and locking of the fragments. All cases should be kept under close observation for a reasonable period immediately following reduction and immobilization. Injured parts should be maintained constantly elevated until all swelling has receded and exposed fingers and toes function well. If excessive swelling occurs in a plaster of paris cast, temporary splitting of the entire length of the cast may be required. This can be closed again as soon as the swelling subsides thus reestablishing the original immobilization. The importance of controlling swelling cannot be overemphasized because many otherwise well treated fractures have had bad functional results due to loss of motion in fingers or toes arising from prolonged circulatory stasis and muscular ischemia. Immobilization should be in plaster rather than splints whenever possible. Splints of metal or wood can seldom be made to conform to the injured part as closely or fit as comfortably as well applied plaster bandages. Failure to use well padded splints or casts of proper length has resulted in unfortunate results in many cases.

Since the time of Hippocrates it has been recognized that "all bones get consolidated more slowly if not properly reduced and immobilized and that exercise strengthens and inactivity wastes." These fundamental principles have been restated by practically every fracture authority and require that: (1) in every fracture the displaced bone ends must be correctly reduced; (2) the reduced fragments must be retained in correct position until bone union has occurred; and (3) maximum function, consistent with complete immobilization of the injured tissues, must be preserved.

Disabilities Due to Treatment

Despite these postulates, some of the more commonly observed disabilities are those of *treatment* rather than *injury*. Stiff fingers and more or less useless hands occur after fractures of the wrist, forearm, elbow, upper arm, and shoulder because swelling was not overcome rapidly, circulation was not restored sufficiently quickly, and fingers were not kept mobile. This resulted in arthritis due to faulty nutrition and deficient oxidation, periarticular adhesions, scarring in and about joints, muscles, and tendons. If function in the fingers and other joints is *not lost* during fracture management, it will not have to be recovered after immobilization of the bone is no longer required. Loss of function in vital parts is not only uneconomical, insofar as prolonging the healing period and amount of treatment is concerned, but may lead to permanent disability which can never be overcome.

Just as common as the neglected hand is the forgotten shoulder which becomes more or less permanently disabled because of disuse associated with the management of fractures of the elbow, forearm, or hand. The surgeon concentrates his attention on the in-

jury in the lower part of the extremity allowing the arm to hang from the shoulder for weeks or months, and when healing of the injured part has occurred and full function of the extremity is undertaken, the long neglected shoulder is found to be irretrievably damaged. It is imperative, therefore, to carry on active movements of remote and uninvolved joints lest restriction of function supervene leading to serious and unexpected disability.

Four Methods of Management

In the management of fractures the surgeon has four basic methods from which to choose: (1) treatment by movement including massage, exercises, modalities, etc.; (2) treatment by continuous traction; (3) treatment by external immobilization with splints, plaster casts, etc.; and (4) surgical intervention with internal fixation of the fragments. He must be familiar with the technic of all these methods and the indications for their use. His choice should be made on the basis of the attainment of the best structural and functional result in the shortest time, with the least expense and hazard to the patient. In the modern management of fractures there have been devised methods which in most instances allow the patient to be ambulatory, do not require extensive hospitalization, and permit the patient to be more or less active preserving function and vitality throughout the uninvolved portions of the body, and maintaining the patient's morale.

One of the most important advances that has been made in the treatment of fractures in recent years is the so-called "walking cast." This device allows the patient to resume early weight bearing while he is still under treatment and achieves end results more quickly and effectively than any other method. Weight bearing on the injured limb stimulates bone union by producing a pressure force upon the callus which hastens its consolidation. Movements of the knee, ankle, and foot are reestablished to a practically normal degree in a much shorter time in individuals who have been ambulatory with weight bearing than in similar cases in which the individual has been confined to bed or has walked with crutches without function of the limb. This is due to neurotrophic stimulation of the joint and its associated structures by protected weight bearing during the convalescence. Muscles are stimulated and maintained in a favorable state by use associated with weight bearing even though motion does not actually occur at the joint. On the contrary, the bed-confined or crutch-dangling limb allows the veins and lymphatics to become incompetent, the limb becomes swollen and cold, and deficient nutrition of all the tissues results. This retards healing of the bone, causes fibrosis in muscles, stiffness in and about joints, loss of motion in the toes, and a prolonged and painful period of rehabilitation.

The use of the walking cast presumes a comprehensive knowledge of accurate fracture reduction by manipulation, traction, or open operation with retention of the reduction through mechanical use of uninjured anatomic structures, wires, pins, or plates, and the use of the completely or relatively unpadded cast equipped with a walking iron or padded sole. Through this means, adequacy of blood supply to the injured limb is maintained, atrophy of cartilage, ligaments, and bone minimized, and loss of function due to these causes avoided. Muscles are induced to exercise against a fixed restraining force and are thereby kept normal in size and activity. Contraction of such muscles is of importance in stimulating a more nearly normal circulation through the limb as a whole, and the circulatory problems following the use of the walking cast are much less significant than after prolonged bed rest or crutch-dangling immobilization.

In instances where physiologic function has not been maintained during the healing of the fracture, effective consideration must be given to the *restoration* of circulation when weight bearing is resumed. At these times, the marked swelling, cyanosis, and reduced nutrition of the limb due to the retarded circulation must be overcome through the use of such a device as the Unna boot, elastic bandage, or other means. Of all the methods available, the Unna boot still represents the most efficient means of permanently overcoming swelling. Such a boot

must be applied only when the swelling is entirely removed from the limb by physiologic drainage through prolonged and continuous preliminary elevation and must be worn as long as the toes show any tendency to swell. Only after the circulation has been completely restored and swelling after pendency overcome has recovery been achieved.

In the upper extremity, fractures of the humerus have recently attracted new interest through the use of the hanging cast of Caldwell. This cast employs the simple principle of traction and is useful for practically all fractures of the humerus except supracondylar and badly comminuted fractures of the head. It consists of a practically unpadded plaster of paris cast extending from the axilla to the wrist with the elbow flexed to an angle of 90 degrees and the forearm in midrotation with a muslin sling extending from a wire loop at the wrist over a felt pad on the back of the neck. The fractured humerus is reduced by manipulation, with or without an anesthetic, before applying the cast, after which the weight of the cast is sufficient to maintain reduction of the fracture by hanging suspended from the shoulder and neck.

Fig. 1. Lateral and anteroposterior views of a hanging cast showing wire loop in cast on radial side of wrist and sling from neck to illustrate principle of traction to arm accomplished by cast. (Taken from Caldwell)

Early motion of the shoulder, wrist, and hand is practiced maintaining maximal function in these parts. Through minor technical changes in the use of the cast, angulation in any direction can be overcome thus leading to union in satisfactory apposition and alignment with the patient up and about. This avoids prolonged hospitalization, bed recumbency, elaborate, uncomfortable, awkward, and unmanageable splints, and hazardous surgery. Although the method violates the principle of absolute immobilization, the remarkable healing power of the humerus seems able to offset this because nonunions have been unsually rare in rather large reported series of cases in which this method has been employed.

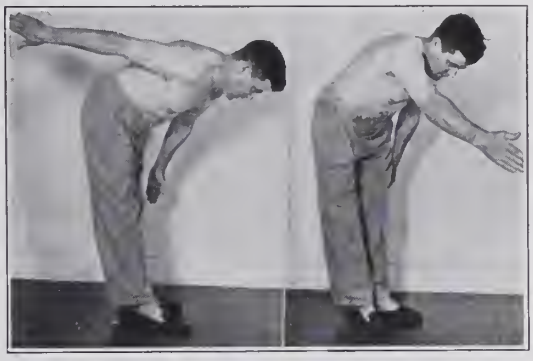

Fig. 2. Swinging exercise with torso bent forward to develop motion and power at shoulder in sagittal plane after removal of cast. (Taken from Caldwell)

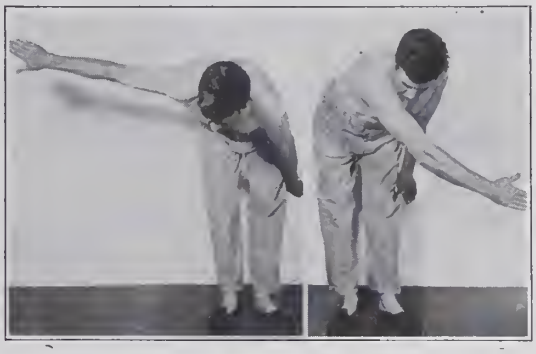

Fig. 3. Swinging exercise with torso bent forward to develop motion and power at shoulder in coronal plane after removal of cast. (Taken from Caldwell)

Renewed interest in the use of metals in the treatment of fractures has been greatly stimulated through the work of Venable and Stuck in the adaptation of vitallium to fracture surgery. Vitallium, an alloy of cobalt, chromium, and molybdenum, is electrically neutral in the body tissues and therefore remains unchanged by body fluid, causes no bone necrosis or demineralization, and maintains indefinitely the mechanical fixation required. Its application to the internal fixation

of fractures has been a great boon to this form of treatment by widening the scope of its use and eliminating many of the complications commonly observed following the employment of other metals in this field. All kinds and types of screws, plates, pins, and caps have been fashioned from this metal and are being used increasingly in the open reduction of simple, comminuted, and even compound fractures, shortening the healing period and reducing ultimate disability.

Perhaps one of the truly remarkable contributions to the treatment of one of the most serious of injuries is the flanged nail of Smith–Petersen for fractures of the hip.

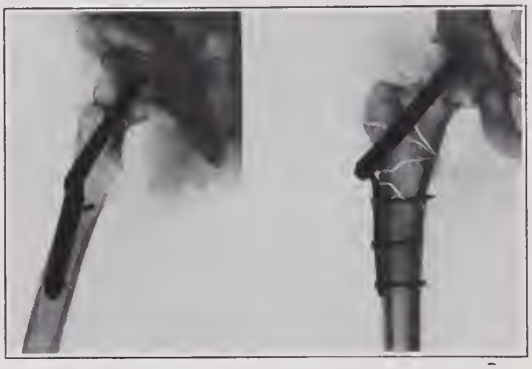

Fig. 4. Lateral and anteroposterior roentgenograms of fractured hip showing Smith–Petersen nail with trochanteric 3-screw plate attached. White lines across trochanteric area indicate other kinds of fracture amenable to this type of internal immobilization.

While I am willing to concede that other types of internal fixation of the hip have also been devised, I regard the principle of the flanged nail as basic and consider its use more satisfactory in the hands of the majority of surgeons than any other device. One cannot fail to be impressed with the simplicity of management of fractured hip cases through this method of internal fixation over what it used to be with the methods that preceded it. These patients no longer require external immobilization in cumbersome plaster of paris casts and within a few days after operation can be moved out of bed and are soon ambulatory with crutches. Complete and prolonged immobilization of the torso and lower extremities is eliminated, extended hospitalization and difficult nursing care is no longer required, marked debilitation and stiffening of joints no longer occurs, and union with maximum function attainable under the circumstances may now confidently be anticipated. The technic of insertion of the nail must be thoroughly mastered, however, before it can be used by the rank and file of surgeons, but when this has once been achieved, no operation can be performed with more assurance and satisfaction than this. Fractured hips, whether within the capsule or without, should no longer be looked upon in despair, but may be approached with as much assurance of success with minimal inconvenience to the patient as many other fractures of less serious implication.

Compound fractures are also seeing a better day. With the knowledge gained from the recent World Wars a more complete comprehension of these conditions has been achieved and real improvement in the management and results attained. Emergency treatment as soon after the injury as possible, careful cleansing of the surrounding undamaged field, copious irrigation of the open wound with saline, removal of all foreign material and devitalized soft tissue and bone, reduction and internal or external fixation of the fractures, restoration of deep and superficial tissues with suture, and complete immobilization thereafter are the important essentials. To this recently has been added the use of sulfa drugs, both in the wound and by mouth, introducing the valuable factor of chemical aid to tissue resistance. The majority of these cases can be managed nearly as well through this method as a simple fracture, and the results are almost as good. Wounds which have become infected or in which treatment has been delayed more than six or eight hours may be treated in the same way as the others but should not be closed by suture. Lactose or pectin packs, closed casts, and infrequent dressings according to the method of Orr are the answer to these cases and will ultimately achieve results consistent with functional usefulness of the part.

Progress has also been made in the management of other special types of fractures leading to shortening of the healing period and improved structure and function. In this

connection, complete or partial excision of the patella following simple or comminuted fractures of this bone is a most striking example of the introduction of a new principle in fracture management. Along with this, one must consider excision of the distal inch of the clavicle in complete acromioclavicular dislocations, which, according to Mumford, greatly simplifies the treatment and restores the patient to usefulness within weeks rather than months, as with the older methods.

Fig. 5. (A) Anteroposterior roentgenogram showing amount of bone removed from end of clavicle for relief of acromioclavicular dislocation or arthritis. (Taken from Mumford)

(B) Photograph showing function at end of six weeks following resection of outer end of the clavicle for subacute acromioclavicular luxation. (Taken from Mumford)

Many other technics and new approaches to the management of difficult problems have been evolved, all tending to shorten the convalescence and improve the end result. The physician who wishes to undertake the management of these cases must keep abreast of progress, must be painstakingly careful in the use of any and every method he employs, must master the technics and devices used, and must be ever mindful of the ultimate purpose of his endeavors. To this must be added the full realization of his responsibilities, not only to his patient but to society as well.

The healing period for fractures in industrial cases must be determined by the surgeon and not the patient. Too often the compensation factor introduces a reluctance on the part of the injured workman to resume useful function in the injured region thereby forestalling recovery and impairing the ultimate result. At this stage of the convalescence the physician must be firm in his management of the case insisting on complete cooperation. Useful work at this stage of the convalescence is far superior to physiotherapy and other forms of treatment because it reduces the introspection of the patient toward his injury, stimulates complete functional activity on the part of the individual as a workman, and divorces the patient from many habits of idleness to which he may have become attached and which he may attempt to preserve through a maintenance of the disabling symptoms which created them. Moreover, purposeful use of an injured part, after adequate healing of the critical tissue has occurred, is the final test of the result which has been attained.

Traumatic Shock*

By CARL W. EBERBACH, M. D.
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THE elusive problem of shock has been attacked by the medical profession with renewed enthusiasm in recent years. Though a few important contributions were made toward our better understanding of the problem at the end of the last century, the most important observations leading to our present conception of shock have appeared during the last decade.

Out of an enormous literature, certain descriptions of shock present a rather clear picture of the condition as we interpret it today, giving us something tangible toward which to direct our therapy.

Among these, we find a definition by Moon in which he describes it as "circulatory failure not of cardiac or vasomotor origin, characetrized by decreased blood volume and blood flow, and an increased concentration of blood."

* Presented before the Postgraduate Industrial Medical and Surgical Clinic of the State Medical Society of Wisconsin, Milwaukee, November, 1942.

Blalock describes the mechanism of shock briefly as follows: "Granting that no definition is entirely adequate, one may state that shock is a condition of the peripheral circulatory failure brought on by a discrepancy between the volume of circulating blood and the size of the vascular system and leads to a deficient blood supply to the tissues of the body. This discrepancy may be due to a reduction of the blood volume, or to an increase in the capacity of the vascular system, or to both. The combination of alterations almost certainly occurs more often than has been suspected."

Harkins describes shock very concisely as a "progressive, vasoconstrictive, oligemic anoxia."

If analyzed, we find shock to be a complex of two acute circulatory disturbances. (Devine) At the outset, we have an acute collapse-like condition with vasodilatation immediately following trauma, which comes on dramatically, runs a rather transient course, is not very lethal, and is of nervous origin. This phase of shock is known as primary or neurogenic shock.

Later so-called secondary or hemogenic shock, which is far more dangerous to the life of the patient, comes on more gradually and results from a reduction of blood volume which sets up the chain of circulatory changes described above.

Causes of Shock

Shock may be brought about by many types of severe injury, but the picture differs somewhat with the trauma. Some of the most common causes are hemorrhage, burns, crushing wounds with extensive muscle damage, visceral and head injuries. With the war have been added an increasing number of blast injuries. In addition to these, there are important contributing causes such as fright, extreme emotional disturbances, pain, exposure and rough handling of tissues and of unsplinted fractures. It is also important to consider here such conditions as old age, malnutrition, dehydration, anemia, hypoproteinemia, and chronic degenerative diseases as possible factors in bringing about shock. (Price)

For many years, the classic picture of this condition has included the following signs and symptoms: pallor, slight cyanosis, a rapid thready pulse, cold sweat, clammy extremities, rapid shallow respirations, hippocratic facies and progressive fall in blood pressure. In hemorrhage, there is generally increased thirst, and respirations usually are deeper. These, of course, are the late signs and symptoms of shock, and it is desirable to make the diagnosis and deal with the problem before this state is reached. Unfortunately, as pointed out by Price, many of our classical tests are not demonstrable until late, and now and again are quite unreliable. A good example of this is the behavior of the blood pressure. Usually in shock there is a progressive fall in blood pressure, but in some extensive burns, the systolic pressure may remain at 100 mm. of mercury or more until just before death. On the other hand, in shock following spinal anesthesia, the systolic blood pressure may drop below 50 mm. of mercury, and the patient will recover. In general, the fall in blood pressure trend is of greater importance than a single low reading of say 60 or 70 mm. of mercury. Likewise, hemoconcentration may not always be a reliable indication of impending shock. The hematocrit rises in burns, crushing wounds and in small intestinal trauma and obstruction, but if these are complicated by hemorrhage, spinal anesthesia, preexisting anemia, dehydration, or other conditions influencing the volume and concentration of blood, it may be misinterpreted. Again, the hematocrit may drop after infusions and plasma injections. It should, therefore, be used as a guide in therapy rather than a criterion for shock. Unfortunately, many tests for preclinical shock, which have been worked out in recent years on experimental animals, cannot yet be applied clinically as most of them are too complicated and tedious.

With these thoughts in mind, how shall we deal with the patient in shock in the light of our most recent advances in shock therapy? Generally speaking, much depends upon the facilities we have to work with and the nature of the trauma which has been incurred. Of first importance is the anticipation and prevention of shock. In severe head injuries, visceral injuries, crushing wounds, hemorrhage and burns, we may be quite certain that shock will occur unless we take steps toward reestablishing a normal circu-

lation before the march of events which leads to circulatory failure appears. Being confronted with the problem of severe trauma, there are no fixed rules to follow, but much depends upon the alertness and judgment of the surgeon. When first seen, it is important that the patient be examined for bleeding. This should be controlled at once and, if possible, without the use of a tourniquet. Tourniquets, as you know, have given rise to dangerous complications such as gangrene of an extremity, or shock upon their removal. Jolly has said that more limbs and lives have been lost by improper use of tourniquets than saved by their proper use. After the control of hemorrhage, the patient should be gently wrapped in warm blankets. Excessive heat might be harmful. Hilgenfeldt and Blalock have shown that excessive heat, which produces peripheral vascular dilatation, may contribute toward the deepening of shock. Morphine may be given to control pain, but its use should be guarded as it contributes towards asphyxia. Fractures must be immobilized with splints. Wounds are best treated without any antiseptics or cleansing until the patient is taken to a hospital or well equipped operating room where these may be dealt with properly. At the outset nothing more should be done than to apply sterile dressings after first "frosting" the wound with sulfanilamide crystals. I might say at this point that the use of the sulfonamides has greatly increased the so-called "safe" period for wound surgery, thereby allowing ample time for the treatment of shock.

If the injured patient comes to operation, much may be done to prevent shock by following certain well established rules. Light anesthesia is desirable, and, except at the hands of an expert anesthetist, open ether is the anesthesia of choice. Avoid spinal anesthesia as it tends to produce shock. Handle tissues gently, control bleeding, avoid unnecessary exposure of viscera. If the patient is dehydrated, it is important to maintain his water balance during the operation, or if considerable blood loss has occurred, start blood or plasma transfusions at once.

When secondary shock has definitely established itself, we have recourse to a number of procedures which are of great value. Among those of first importance, perhaps, is the use of whole blood to reestablish blood volume. Saline and glucose solutions are of little value at this stage as the need for water and electrolytes is slight. In fact, they may actually do harm by increasing the edema of the tissues. Though there are many blood substitutes, some of which are still being considered experimentally, the most valuable of those available to us at the present time are plasma and serum. These substances increase the colloid osmotic pressure and reestablish blood volume. They are best given in small doses at the outset, except when severe hemorrhage has occurred, and their use should be continued until a sufficient quantity has been added to reestablish a satisfactory blood volume.

Transfusions

In severe hemorrhage, obviously the administration of whole blood is the ideal therapeutic procedure. Transfusions, however, should be performed promptly to prevent irreversible tissue reactions which may result from prolonged anoxia. If whole blood is not immediately available, plasma or serum may be used as they are equally valuable in reestablishing blood volume and prevent irreversible reactions as has been shown by Best and others.

In burns and crushing wounds, plasma is ideal as the extensive loss of fluid from the vascular bed in these lesions results in hemoconcentration. The red blood cells of whole blood are therefore superfluous and may even be harmful as they increase the viscosity of the blood.

Among other therapeutic measures which have been found of value we must include oxygen. Its use is logical in combating the anoxia of the tissues and irreversible tissue damage, but it has not proven to be as useful as has been anticipated. It is most effectively administered through a BLB mask. However, if the mask is not available or not tolerated, a tent or nasal catheter may be used.

Recently, adrenal cortical substance has gained a certain degree of popularity. It is said to help restore normal permeability of the capillaries to proteins. We also know that experimental animals with deficient adrenal cortex are more susceptible to shock. Theoretically, therefore, it should be useful. I use it frequently for my own patients, but it is difficult to appraise its value as it is always administered in conjunction with other therapeutic measures. I gain the impression, however, that the recovery from shock is much more rapid with its use than without it. Adrenalin is of relatively little use in secondary shock as the vasoconstriction, which it is designed to produce, already exists. In primary shock, on the other hand, in which there is transient vasodilatation, it is exceedingly effective. Countless drugs have been used over the years to "stimulate" the patient, but none can be demonstrated to have real value in secondary shock.

In conclusion, may I say that in the light of our present knowledge of the pathologic physiologic changes in shock, we are now able to deal with the problem more intelligently than ever before. We should, therefore, importantly cut down the mortality in this otherwise very lethal condition. If we fail in this, it is because we are not keeping abreast of medical science.

ORTHOPEDIC FIELD CLINICS

JANUARY 1, 1943 TO JULY 1, 1943

Transportation is difficult; tires and gasoline must be conserved. Few of us need to be reminded of these facts, but many are prone to forget the significance of a statement recently made by the President. He said, "While we fight this global war, we must see to it that the health of our children is preserved and protected—for tomorrow's America will be as strong as today's children." In 1941–42 there were 1,033 children at the field clinics. Who can estimate the contribution which the clinics made to our nation's future?

We believe that the early announcement of the dates and a few items of information will enable the cooperating agencies and persons to plan more economically and effectively for the clinics. For your fine work in the past, we thank you on behalf of Wisconsin's children.

SCHEDULE

Sheboygan	March 5
Racine	March 19
Kenosha	March 31
Green Bay	April 16
Eau Claire	April 28
La Crosse	May 11
Superior	May 21
Ashland	May 28

For. The clinics conducted by the Crippled Children Division are for persons under twenty-one years of age.

Referral. All referrals to the clinics for examinations must be made by the family physician. We urge the parents to take their child to their physician before asking for a referral.

Referral Blanks. Blanks for the purpose of referral may be obtained from the Bureau for Handicapped Children.

Time of Referral. Referral blanks signed by the physician should be sent to the Bureau for Handicapped Children at least thirty days in advance of the clinic date so we may notify the family of the hour for examination.

Parents. Parents and physicians are invited to attend the clinic with the child. If the public health nurse feels that the child referred to the clinic for orthopedic reasons is also in need of other services, please feel free to write.

Address Correspondence to: Bureau for Handicapped Children, Room 146 North, State Capitol, Madison, Wisconsin.

Comments on Treatment

Editors—A. J. QUICK, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Plasma in Severe Burns

Only after great catastrophies such as Pearl Harbor and the Cocoanut Grove fire in Boston are the recent advances in therapy brought forcefully to our attention. Endless research on the treatment of burns in these instances paid large dividends in terms of human lives saved.

It is now clearly recognized that in severe burns the treatment must be both local and systemic. In the former, the object is first to form a coagulated film over the denuded area for the prevention of serum by oozing; and secondly, to keep the burned area free of infection. The first step is to clean the involved area with soap and water, débride where necessary, and then spray with a freshly prepared 10 per cent solution of a tannic acid. This is followed by the application of a 10 per cent silver nitrate solution. No dressing is applied except to small localized areas. The vaseline gauze pressure dressing is sometimes of value in reducing local oozing. For burns on face, hands, feet, and genitalia, petrolatum and 1 per cent sulfanilamide are to be recommended. These parts of the body should not be treated with tannic acid. Affected areas are kept under a warm air cradle maintained at 75 F. to 85 F.[1]

In the systemic treatment, the first step is to alleviate pain and anxiety. Analgesics and sedatives are particularly valuable, but care must be taken not to use them excessively, or too long, since they are likely to accentuate the anoxia that occurs in shock. The value of rest, quiet, and warmth is self evident, but care must be taken not to have the temperature in the cradle or tent above 85 F. It is well to recognize the value of oxygen. Often the administration by nasal catheter is sufficient, but in the more serious cases an oxygen tent may be required. Good results in treating shock have been obtained with adrenal cortex hormone (cortical extract as well as synthetic desoxycorticosterone acetate).

All the measures enumerated are often inadequate to control or treat shock, which invariably sets in after severe burns. At present, only one effective treatment is known, and that is the prompt intravenous administration of an adequate amount of human plasma. It is, therefore, of paramount importance to know how much plasma to give. Studies by Harkins and associates,[2] supply a valuable guide. These authors list several methods suitable for calculating the quantity of plasma needed. Two of these are particularly suitable when adequate laboratory facilities are not available. The first depends solely on surface area burned. The rule is to give 50 cc. of plasma for every per cent of the body surface affected. The per cent of area involved can be roughly calculated on the basis that the head constitutes 6 per cent of the total body surface, one arm 6.75, one hand 2.75, one thigh 9.5, one leg 7, one foot 3, and the trunk 38 per cent.

The second method depends on hemoconcentration and requires that cell volume be determined by means of a hematocrit. The rule is to give 100 cc. of plasma for every point the hematrocrit exceeds the normal of 45 degrees. Both methods are based on adult requirements. For children, the amount thus calculated is corrected on the basis of body weight. The plasma is given slowly as follows: one-third during the first two hours, one-third during the next four hours, and the remainder during the next six hours. A. J. Q.

[1] Editorial: War Casualties at Pearl Harbor, J. A. M. A. 120: 1217 (Dec. 12) 1942.

[2] Harkins, H. N., Lam, C. R., and Romence H.: Plasma Therapy in Severe Burns, Surg., Gynec. & Obst. 75:410 (Oct.) 1942.

Prominent Wisconsin Physicians Appointed to State Board of Health

FOUR prominent Wisconsin physicians were appointed members of the Wisconsin State Board of Health by Governor Walter S. Goodland on January 15. Under the statutes these appointments were subject to confirmation by the Senate, and on January 29 all appointments met with unanimous approval of the upper house. The new members of the Board are all members of their county and state Societies, and have long been prominent in medical circles.

A. E. RECTOR

Dr. Albert E. Rector was chosen by Governor Goodland to succeed Dr. Joseph Dean of Madison, whose original appointment was for the term ending in February, 1939, but who has continued to serve until his successor was appointed and qualified. Senator John F. Lappen, representing Shawano and Outagamie Counties, spoke in favor of Dr. Rector and praised him as one "active in civic affairs." Dr. Rector will serve the balance of the term, ending February 1, 1946.

Long prominent in the medical profession, Dr. Rector was born in Fennimore, Wisconsin, in 1873. Following his graduation from Rush Medical School in 1897, he spent five years in the general practice of his profession in Iowa. He then took two years of postgraduate work in diseases of the eye, ear, nose and throat in Chicago and New York City, and in 1905 located in Appleton where he has since remained in continuous practice of his specialty, except for European postgraduate studies in 1914.

Dr. Rector is past president of the Outagamie County Medical Society, the Central Wisconsin Society of Ophthalmology and Otolaryngology, and the State Medical Society of Wisconsin. He is a Fellow of the American Medical Association and the American College of Surgeons, a member of the American Academy of Ophthalmology and Otolaryngology and a licentiate of the American Board of Otolaryngology. He was Speaker of the House of Delegates of the State Medical Society of Wisconsin in 1936–37, and at the present time is an alternate delegate of that organization to the American Medical Association, and is serving as chairman of the Committee on Grievances of the State Society.

GUNNAR GUNDERSEN

Dr. Gunnar Gundersen was appointed for a term ending in February, 1944, as successor to Dr. Cornelius A. Harper, who recently resigned as state health officer and as a member of the State Board of Health, and who has been named a specialist in the department. When Dr. Gundersen's appointment came before the Senate for confirmation, Senator Rudolph M. Schlabach, representing Jackson, La Crosse and Trempealeau Counties, praised Dr. Gundersen as a physician highly qualified in his profession and "a man of high character and independent thought who is well qualified to enter upon the duties of the State Board of Health."

Dr. Gundersen was born in La Crosse, Wisconsin, on April 6, 1897. He is a son of the late Dr. Adolf Gundersen, pioneer physician and surgeon of La Crosse. He is one of seven brothers, all but one of whom are physicians and three of whom are associated with him in the practice of medicine.

He was graduated from the University of Wisconsin's two-year medical course, and received his M. D. from the College of Phy-

sicians and Surgeons, Columbia University, in 1920. He was licensed in Wisconsin in 1920.

Dr. Gundersen is attending surgeon at the La Crosse Lutheran Hospital, a fellow of the American College of Surgeons, a member of the American Board of Surgery, and a past president of the State Medical Society of Wisconsin. He is at present chairman of the Society's Committee on Industrial Health and a member of the Committee on Public Policy.

I. F. THOMPSON

Dr. Ira F. Thompson was appointed to succeed Amalia Olson Baird, Eau Claire, and holds a term to expire in February, 1945. When Dr. Thompson's name was brought before the Senate for confirmation, Senator Edward F. Hilker, representing Racine County, endorsed Dr. Thompson's appointment and qualifications to serve on the State Board of Health.

After being licensed to practice medicine in Wisconsin, he spent four years in practice in Beloit and ten years in Reedsburg from 1904 to 1914. He received his masters in public health from the University of Wisconsin in 1915 and held the office of deputy state health officer from 1916 to 1919, after which he organized and directed the Bureau of Venereal Disease of the State Board of Health from 1919 to 1921. Dr. Thompson served as Deputy Commissioner of Health for the city of Milwaukee from 1921 to 1923 and in 1924 was Acting Commissioner of Health in that city. In 1924 he went to Syracuse, New York, returning in 1932 to Wisconsin. From that date to the present time he has been Health Officer of Racine.

W. T. CLARK

Dr. William T. Clark takes the place of Dr. Robert L. MacCornack, Whitehall, whose term expired in February, 1942, but whose successor has not been previously named. He holds a term expiring in February, 1949. Senator Robert P. Robinson, of Beloit, representing Rock County in the Senate, commended the appointment of Dr. Clark whom he praised as a man held in "very high regard and well qualified to serve on the Board."

Dr. Clark was born in 1882 and received his medical education at the Hahnamann Medical College, Chicago, in 1907. He received his Wisconsin license in 1910 and practiced medicine in Fort Atkinson from 1910 to 1917. He served one year in the armed forces during World War I, after which he took up his practice in Janesville where he has been active ever since. Dr. Clark is a member of the American Board of Radiology, the Radiological Society of North America, Inc., and the American College of Radiology. He is a Councilor of the State Medical Society of Wisconsin from the Third District, a former member of the Society's Committee on Maternal and Child Welfare, and of the Committee on Tuberculosis and Chest Diseases. He is a past president of the Rock County Medical Society.

BY-LAWS, CHAPTER VIII, SECTION 1

". . . Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted."

THE NATION AT WAR

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

BLOOD PLASMA AVAILABLE IN WISCONSIN

The night club fire in Boston demonstrated the need for general knowledge of the availability of blood plasma. It is available in Wisconsin in a number of strategic locations. Some has been made available by the Office of Civilian Defense in the completely processed dried form, and some frozen plasma has been prepared for storage purposes. This plasma is primarily designed to care for casualties resulting from enemy action. However, the Office of Civilian Defense has ruled that it may be used for the care of victims of a major catastrophe such as that in Boston.

In the event that a disaster strikes your community, your county chief of Emergency Medical Service may request this plasma from Dr. J. S. Supernaw, Madison, State Field and Casualty Officer of Emergency Medical Service, or from one of the following assistant state chiefs of Emergency Medical Service:

T. C. Hemmingsen, M. D., Racine
A. G. Koehler, M. D., Oshkosh
F. G. Anderson, M. D., Eau Claire
V. E. Ekblad, M. D., Superior

The reserve supplies of plasma in Wisconsin are at the following locations: Madison, 200 units USPHS dried plasma, J. S. Supernaw, M. D., telephone, Badger 6882 office, and Fairchild 4540 residence; Superior, 100 units, V. E. Ekblad, M. D., telephone, 38R1; Oshkosh, 100 units, A. G. Koehler, M. D., telephone, 3722W; Milwaukee, Columbia Hospital, 500 units frozen plasma; Eau Claire, Luther Hospital, 200 units liquid plasma, and Eau Claire Ordnance Plant, care of Dr. J. H. Wishart, twenty-five units liquid plasma.

USE OF FROZEN PLASMA

Inasmuch as physicians may, with increasing frequency in the future, be called upon to use frozen plasma, the Office of Civilian Defense has issued a notice on the handling of storage and use of frozen plasma. The notice which was prepared by John B. Alsever, Surgeon (R) USPHS, Technical Director of the Blood Plasma Section, is printed below in its entirety.

Additional important information concerning the handling of the supply of frozen plasma which you are storing for this office is contained in the following paragraphs. Will you please be sure that the persons responsible for handling this plasma in your hospital become familiar with this information.

It has been determined by experiments that in rare instances thawing of this frozen plasma causes the stopper to blow out of the neck of the bottle. The reason for this is quite apparent when one considers that these stoppers were placed in the bottles after the plasma had been frozen and in a room where the temperature was —20 C or lower. This would be a more frequent complication if a sleeve type stopper were not used. It is important, therefore, that the bottles be closely observed during the thawing period, so that a bulging stopper may be detected before it blows out. The increased air pressure within the bottle can be relieved immediately by the insertion of a sterile needle, which can then be promptly withdrawn. You should have on hand two or three such air release sets. These should consist of a sterile twenty gage needle to which is attached a short piece of rubber tubing approximately one inch long. A short piece of glass tubing containing a plug of absorbent cotton should be inserted into the other end of the tubing to avoid the possibility of introducing any dirt into the bottle. These sets should be wrapped and autoclaved so that they are always ready for use.

The proper procedure when a stopper is observed to be bulging is as follows:

1. Thoroughly wipe the top of the stopper with tincture of iodine;
2. Insert the needle of the sterile air release set through the stopper;

3. A moment will be sufficient to allow the release of pressure, and the needle can be withdrawn.

If this is properly done in a sterile fashion as directed, it is a safe procedure and will not contaminate the plasma. It is emphasized that it should be necessary to do this only rarely.

With further reference to the advisability of administering this plasma within twenty-four hours of the time of thawing, it is requested that as soon as it is determined that any thawed plasma cannot be used within this period of time, it should immediately be refrozen.

The following will amend the paragraph in the original letter regarding the occurrence of a power failure. It has been determined that if this should happen, and the storage cabinets are operating at a temperature of —20 C, it will take from four to six hours for the cabinet temperature to rise to a point where the plasma will begin to thaw.

It has been found that the cabinet temperature can be maintained satisfactorily for indefinite periods of time by the use of dry ice. Therefore, it is now recommended that if a power failure occurs which cannot be remedied within three or four hours, dry ice be obtained and placed in the storage cabinet, thereby maintaining the plasma in the frozen state. This should be continued, if possible, until the current is restored and the cabinet is again in operation.

From experience in the shipment of frozen plasma, it has been determined that 100 pounds of dry ice will maintain a cabinet temperature of —20 C for at least forty-eight hours. If a situation should arise which necessitates that the hospital furnish dry ice for this purpose, this office is prepared to reimburse the hospital upon the submission of paid invoices or receipts. This office should be notified immediately if any such circumstance occurs. Should it be impossible to obtain dry ice, the original instructions should be followed.

DEFENSE WORKERS CASUALTIES COVERED BY FEDERAL FUND

All civilian defense volunteers, including trainees and training staffs and members of the Civil Air Patrol and the Aircraft Warning Service, are eligible for federal compensation or medical services in case of death or injuries resulting from their participation in assigned civilian defense activities, provided that the claims are properly recorded with the civilian defense officer of the applicant's county or local corps.

It is, therefore, essential that county or local personnel officers be appointed immediately, or if already appointed, that they have their personnel and enrollment records up-to-date in order to be able to handle all casualty reports promptly. Personnel officers are responsible for the personnel and enrollment records, as well as all records in respect to casualties, of all members of defense corps in their respective areas.

Funds for this claim service are provided for in a $5,000,000 presidential allocation known as the "Emergency Fund for the President." Instructions and procedures for establishing claims under this act are governed by the Federal Security Administrator. The Wisconsin Council of Defense will issue directives on the subject in the near future.

LIMITED NUMBER OF RECOMMENDED CONTAINERS FOR FIRST-AID POST UNITS AVAILABLE

Captain Joseph W. Lambert, formerly Field and Casualty Officer for Emergency Medical Service, had constructed, before leaving for service, a number of containers in which to place the equipment called for by the Office of Civilian Defense. (List No. 1) These boxes are made in accordance with the specifications outlined in the Handbook for the Chiefs of Emergency Medical Service.

Captain Lambert writes from Fitzsimons General Hospital, Lowry Field, Denver, Colorado, advising the Society that the Vocational School made a larger quantity than were immediately needed in his district, and he has asked that Chiefs of Emergency Medical Service be advised of the availability of these containers.

If any Chief of Emergency Medical Service in Wisconsin desires to avail himself of one of these containers, he may do so by writing to the Society's office in Madison.

LOAN PACKETS ON AVAIBLE SCIENTIFIC MOTION PICTURES

Motion pictures will play an increasingly important role in postgraduate medical education for the duration of the war. In order that secretaries and program chairmen of county medical societies might have readily available reference material, the secretary's office of the State Medical Society has collected from numerous sources motion picture film catalogues for mailing to officers of county medical societies in order that they

might select the pictures of current interest to them.

Many excellent scientific motion pictures, both sound and silent, will be found in these catalogues. District health officers who have in their possession at all times a sound motion picture projector are as follows:

District 1—Dr. A. R. Zintek, State Office Building, Madison
District 2—Dr. R. N. Nelson, Municipal Building, Elkhorn
District 3—Dr. V. A. Gudex, Court House, Fond du Lac
District 4—Dr. C. W. Meinershagen, 110½ West Oak Street, Sparta
District 5—Dr. Arthur R. Van Duser, P. O. Box 270, Wisconsin Rapids
District 6—Dr. Allen Filek, City Hall Annex, Green Bay
District 7—Dr. F. P. Daley, Rutledge Charities Building, Chippewa Falls
District 8—Dr. Frances Kline, City Hall, Rhinelander
District 9—Dr. M. W. Meyer, Vaughn Library Building, Ashland

The secretary's office will be happy to forward on request the loan packet.

MILITARY NOTES

Lieutenant Joseph J. Furlong, U. S. N. R., of Milwaukee, is at present assigned to Moffett Field, California. He writes that he, along with Dr. Gordon G. Feldman and Dr. Joseph W. Rastetter, both of Milwaukee, are in training there. Also at Moffett Field is Dr. Alvin Florin of Fond du Lac and Dr. Richard Jensen of Neenah. In San Francisco is Dr. Burchell of Milwaukee.

* * *

Major Howard J. Lee, whose home town is Oshkosh, writes from Fort Leonard Wood that he is at the present time the only Wisconsin physician located at that particular station hospital.

* * *

Writing of his assignment to Carlisle Barracks, Pennsylvania, Captain R. W. Hammond of Manitowoc states that he is there for a six weeks' course and then will be transferred to a medical reserve pool. In his class, the nineteenth, there were many doctors, with a new class starting every two weeks. He states that Southerners seem to predominate at Carlisle Barracks and that he has not as yet met any Wisconsin men. They have classes eight hours daily, six days a week.

DIED IN THE SERVICE OF HIS COUNTRY

T. D. HUNT

Lieutenant T. Dwight Hunt, 36, was killed in an airplane crash at Pueblo, Colorado, on January 24.

Lieutenant Hunt graduated from the University of Oregon Medical School in 1935 and was licensed to practice medicine in Wisconsin in 1940. He was called to active duty in the Medical Corps of the United States Army Air Corps in September, 1942, and reported for duty at Selfridge Field, Michigan. He was later transferred to Pendleton Air Base, Oregon, and then to Carlisle Barracks, Pennsylvania. Only recently had he been stationed at Pueblo, Colorado.

He is survived by his parents, the Reverend and Mrs. George Hunt, 1906 Westlawn Avenue, Madison.

The *Journal* has received a letter from Captain Kenneth D. Hannan, whose mailing address is now San Francisco. He sends his thanks to this office for remembering the men in service with the "news letter" which was the first of a series of such letters to be sent to our men in the armed forces.

* * *

Captain R. L. Waffle, formerly of Fond du Lac, writes from "somewhere in the South Pacific" as follows: "While I was still in Australia I had been receiving the *Journal* regularly, and I did enjoy reading what was going on in the home medical circles. However, since being here in the South Pacific I have not received a magazine of any kind for nearly two months.

"Our voyage from the United States was very long, and the latter half of the trip was warm with rough weather. Upon arriving I met Colonel Bleckwenn (from the staff of the Wisconsin General Hospital) and Major Erwin Ludwig of Wausau (a former classmate of mine at the University of Wisconsin). I found they had been in the same convoy as ours, but they were on another boat.

"I saw quite a good deal of the populated parts of Australia and helped to run two small hospitals in different parts of the country. Australia as a whole is a very easy going country. However, they are rapidly becoming Americanized, and I am sure the country will be much more progressive by the time this war is over.

"A month or so ago we were moved up here to this island. This is a very rough country of mountains and jungles, and I have seen a great deal of them both. We are plagued by flies and a thousand

different insects most of which have a biting apparatus of one kind or another. We also have many small lizards and some crocodiles on the stream where we go bathing. There are many natives around here, but they are nearly all friendly, a fact for which we are very happy.

"There are just a host of things I would like to tell you about, regarding the war effort over here and where we fit into the picture, but will have to wait until the war is over to relate it."

* * *

Lieutenant A. L. Reinardy, formerly a practicing physician at Stevens Point, writes from "somewhere in the South Pacific" as follows: "I feel the urge to add my small voice to the many who are writing you in praise of your recent news letter innovation. In my opinion it is a splendid and much appreciated idea. Please keep it up."

* * *

Also from "somewhere in the South Pacific," Lieutenant Commander H. J. Schilling writes that he is happy to have received the news letter and recent copies of the *Journal*. He writes that he is enjoying his work immensely. He states that in all types of cases, including gasgangrene, the mortality rate is still very low. He gives considerable credit to the first aid given the patients before they are received at the hospital.

He feels that every American has the right to be proud of our fighting men and states that "our country's parents are to be congratulated on the splendid quality of young manhood we have here in action against the enemy. Everyone here is most optimistic about the future, for we know and feel ours to be the winning side."

* * *

Lieutenant Harry L. Schwartz, formerly of Kenosha, writes from Nashville, Tennessee, that he is in the process of becoming a flight surgeon. He just finished the course at Randolph Field.

* * *

A communication from Lieutenant Farrell F. Golden, whose home town is Ashland, indicates that he is on duty "somewhere in the South Pacific."

* * *

Lieutenant Commander James J. King, Milwaukee, is at present stationed at the United States Naval Hospital at Memphis, Tennessee.

A letter received through the Postmaster in New York from Captain Lawrence H. Feiman, Milwaukee, states that he has been receiving the bulletins and the *Journal* with fair regularity since being on overseas duty.

* * *

Lieutenant B. A. Ruskin, formerly practicing in Wauwatosa, writes from Camp Bowie, Texas, as follows: "Your reports regarding the news of the Society 'back home' have been very much appreciated and have kept alive the bridge between our present duties and those associations we had and hope to resume. As you suggested, 'keep 'em coming.'

"The *Journal* comes in regularly, and is read not only by myself, but everyone else from almost every other state."

* * *

Appreciation for the news letter also comes from Lieutenant Commander N. E. Bear, whose home town is Monroe, but now stationed in the Caribbean area. He finds his experience in service to be very valuable and is well satisfied with his assignment. He states that the Navy is treating him very well and enjoys devoting his time to military service.

* * *

Lieutenant Carl Milchen, former Blair physician, writes from Fort Bliss, Texas, that he enjoys army life. His first station was Waco, Texas, and is now at El Paso.

* * *

Writing from Seattle, Washington, Lieutenant R. E. Galasinski, Milwaukee, states that being in the Medical Corps of the Navy is keeping him busy. He finds little time for keeping up correspondence with friends back home, and consequently the *Journal* and news letters provide a source of information of what is going on on the home front.

* * *

Lieutenant John Martineau, who practiced at Elkhart Lake for several years, writes from the Hawaiian Islands that he is being kept busy as an officer of the Medical Corps. He finds the Islands interesting and describes in great detail the beauty of his surroundings.

* * *

Dr. Edson J. Andrews, a native of Manitowoc and a former resident of the Milwaukee County Hospital, has been assigned to the Station Hospital, Hamilton Air Field, California.

IMPORTANT NOTICE

The state consultant in Wisconsin for the Procurement and Assignment Service for Physicians asks that Wisconsin physicians who have applied for service with one of the branches of the armed forces and have been rejected on physical grounds forward at once two copies of the notice of rejection to the state office of the Procurement and Assignment Service, 2750 North Teutonia Avenue, Milwaukee. This is to enable that office to clarify the status of Wisconsin physicians and to avoid recertification of men as available for service who already have been rejected.

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« « « EDITORIAL » » »

No Rationing of Health

WAR inevitably brings to many a general feeling of unease and sometimes an unexpressed fear of an intangible character. It appears that there is much concern in the minds of some that with physicians being required in such large proportion by the armed services, the Procurement and Assignment Service is actually engaged in the rationing of physicians, dentists, and veterinarians.

It is time for clear thinking, for the rationing of physicians between the two major groups requiring their services does not necessarily imply that health is to be rationed insofar as community needs are concerned. After all, those in the armed services would require medical attention whether they were in or out of service.

Secondly, the very purpose of the Procurement and Assignment Service would be defeated if it were engaged in the rationing of health. The procurement of medical officers constantly is being readjusted to civilian health needs. In Wisconsin, for example, there are many areas where physicians have been retained in their local communities regardless of the fact that, individually, some of them are particularly eligible for military service. This has been done because, in the judgment of the Procurement and Assignment Service, the number of physicians available to serve community health needs is not subject to readjustment in that area.

Neither has the Procurement and Assignment Service accepted a provincial approach to the problem. It has not ruled the State of Wisconsin into theoretical squares and established a fixed proportion for the contribution of medical men based upon the number of physicians in those communities in relation to one another. To establish such a program would be to ignore the purpose of the Procurement and Assignment Service to protect the ratio of medical men to community population.

The Procurement and Assignment Service is doing its work well and with a devotion to its purposes that could only be self imposed. It is very evident that the hue and cry that has been heard throughout the country for doctors has not been raised in this state. This is due to the fact that the Procurement and Assignment Committee in this state has been unusually careful in its selection of doctors who might be marked available.

. . . . THE PRESIDENT'S PAGE . . . .

Four Wise Choices

AS THIS President's Page is being dictated, word comes to your President of the appointments of Dr. Gunnar Gundersen, La Crosse, Dr. A. E. Rector, Appleton, Dr. W. T. Clark, Janesville, and Dr. I. F. Thompson, Racine, as members of the State Board of Health in Wisconsin.

Governor Walter S. Goodland has made an excellent impression upon the medical profession of Wisconsin in these four wise choices. Elsewhere in this issue of the *Journal* appears a biographical sketch of these four physicians, all of whom have been prominent in fulfilling their civic and professional responsibilities in the field of public health. That they will ever bring to the Board a broad concept of its functions, its duties, and its responsibilities goes without saying, for the State Board of Health is peculiarly an administrative body of this state, in which the State Medical Society of Wisconsin takes great pride, not alone because it has the privilege of working with that body toward the end of public health protection, but also because the Board was established in 1876 as a result of the efforts of the medical profession of Wisconsin over a period of many years.

The State Board of Health is charged with a multitude of responsibilities. Under it and with the cooperation of the entire medical profession of Wisconsin, this state is honored by the fact that it is considered among the three healthiest states in the Union. This is no accomplishment alone of statistical importance, because health achievements are accomplished only as a result of long and far-seeing efforts and a unanimity of purpose and objective on the part of all who contribute to that end.

In the appointment of Doctors Gundersen, Rector, Clark and Thompson, the people of Wisconsin are assured of the continuance of good service to the cause of public health, and in the appointment of these physicians Governor Goodland is to be commended.

F E Butler

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(ORGANIZED 1929)

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The Bulletin

By MRS. WILLIAM A. WAGNER
Oshkosh

THE Woman's Auxiliary to the American Medical Association, which was organized in May, 1922, is a valuable organization available to national defense. Our Auxiliary is national in scope, and in the present emergency each and every member should render what assistance she can in our nation's war effort; namely, the sale of United States Defense Stamps and Bonds, the promotion of health education among lay groups, the promotion of classes in nutrition and nurses' aide groups, and, in fact, cooperation and assistance in all forms of national defense programs.

The Bulletin, which is the official publication of the Woman's Auxiliary to the American Medical Association, is the most helpful aid for all members of the Auxiliary who are now engaged in this work. It contains excellent material prepared by our national officers and committee chairmen. *The Bulletin* carries the official programs of the national organization, which every auxiliary member should know. Through *The Bulletin* each individual group can be kept well informed as to the plans and accomplishments of other auxiliaries. This also serves as a measuring stick for the accomplishments of your own group. It not only helps your county organization in its own individual programs, but keeps the members well informed on what the state and national organization is accomplishing.

The Woman's Auxiliary to the American Medical Association has established a central office in Chicago with Miss Margaret Wolfe in charge. Miss Wolfe has a splendid background for this work. She superintends the compiling and publication of *The Bulletin* and assists in coordinating the work of the various committees.

It is the wish of our state president, Mrs. E. S. Schmidt, that every county chairman and committee chairman subscribe to *The Bulletin,* and it is the duty of every member of the auxiliary to read *The Bulletin* in order to be a well informed, interested, and active member.

Please send subscriptions for *The Bulletin* to Mrs. W. A. Wagner, State Bulletin Chairman, 344 Merritt Street, Oshkosh, Wisconsin.

County Auxiliary Proceedings

Brown—Kewaunee—Door

When the Brown–Kewaunee–Door County Medical Auxiliary convened on October 22 at the Beaumont Hotel, Green Bay, members took pride in noting five state officers and committee chairmen in their group. They were Mrs. E. S. Schmidt, state president; Mrs. L. D. Quigley, corresponding secretary; Mrs. D. F. Gosin, program chairman; Mrs. D. B. Dana, chairman of press and publicity, and Mrs. A. J. McCarey, chairman of the special committee on war activities.

After the luncheon, high lights of the annual meeting in Milwaukee were described by Mrs. E. S.

Schmidt. Mrs. L. D. Quigley reported that this unit received honorable mention at the convention for having exceeded its quota in *Hygeia* sales.

Mrs. McCarey read a comprehensive statement which she had sent to all county auxiliaries, urging that each member affiliate herself with at least one war activity. An individual record of hours will be turned in to Mrs. McCarey at intervals. Some time ago Mrs. Schmidt requested that members of the Brown–Kewaunee–Door Auxiliary work on surgical dressings, and a very active group is now doing so.

New officers for 1943 are:

President—Mrs. T. S. Burdon
President-elect—Mrs. R. W. Burns
First vice-president—Mrs. A. A. Filek
Second vice-president—Mrs. O. W. Saunders
Recording secretary—Mrs. P. F. Dockry
Corresponding secretary—Mrs. R. M. Waldkirch
Treasurer—Mrs. G. F. Denys
Parliamentarian—Mrs. E. S. Schmidt
Auditor—Mrs. N. M. Hersten

The following committee chairmen have been announced:

History and Archives—Mrs. P. R. Minahan
Social—Mrs. E. S. McNevins
Hygeia—Mrs. George Goggins
Philanthropic—Mrs. R. B. Lenz
Program—Mrs. J. E. Halloin
Press and Publicity—Mrs. D. F. Gosin
Telephone—Mrs. W. W. Ford
Membership—Mrs. M. H. Fuller
Flowers—Mrs. R. W. Kispert
Legislation—Mrs. E. S. Schmidt
War Activities—Mrs. W. T. Hagerty

Mrs. T. S. Burdon, newly elected president of the Woman's Auxiliary to the Brown–Kewaunee–Door County Medical Society, took charge of the luncheon meeting held on December 9 at the YWCA, Green Bay.

There was a discussion on the question of dues of members who are absent because their husbands are now in the armed forces, and the secretary was instructed to write each member, asking whether she wished her name kept on the membership roll.

Mrs. E. S. Schmidt read an inspiring Christmas message in which she urged greater interest in civilian defense, community health education, Red Cross activities, programs for cancer control, and classes in nutrition, first aid, mental hygiene and nursing.

A report was given on participation in the community war chest drive, and members were asked to contribute at least one day to the campaign. The group adjourned to work on surgical dressings.

Columbia—Marquette—Adams

Members of the Woman's Auxiliary to the Columbia–Marquette–Adams County Medical Society met with their husbands at the Hotel Raulf, Portage, for dinner on November 19. Following the dinner each group held its monthly business meeting.

New officers elected are:

President—Mrs. J. H. Houghton, Wisconsin Dells
President-elect—Mrs. H. E. Gillette, Pardeeville
Secretary—Mrs. E. F. Tierney, Portage
Treasurer—Mrs. W. A. Taylor, Portage

The committee chairmen were announced as follows:

Program—Mrs. J. W. MacGregor, Portage
Hygeia—Mrs. L. V. McNamara, Montello
Press and Publicity—Mrs. E. F. Tierney, Portage
Philanthropic—Mrs. G. L. Treadwell, Friendship
Social and Membership—Mrs. C. W. Henney, Portage

Twenty-one dollars was raised by the auxiliary for material for curtains to be used in the medical officers' dayroom at Truax Field, Madison.

WE HAVE A NEW AUXILIARY

Mrs. E. S. Schmidt, state president, is pleased to announce the formation of a new county group, the Woman's Auxiliary to the Crawford County Medical Society.

The auxiliary was organized on December 10, and the following officers were elected:

President—Mrs. O. E. Satter, Prairie du Chien
Vice-president—Mrs. T. F. Farrell, Prairie du Chien
Secretary–Treasurer—Mrs. E. T. Ackerman, Gays Mills

A newly appointed Social and Program Committee, headed by Mrs. E. M. Dessloch, Prairie du Chien, will study the Constitution and By-laws and report at the second meeting, which is to be held in Prairie du Chien on January 15.

Dane

The regular monthly meeting of the Woman's Auxiliary to the Dane County Medical Society was held on November 9 at the home of Mrs. H. L. Greene, Maple Bluff.

At the luncheon Mrs. G. G. Stebbins, chairman of the hostess committee, was assisted by Mmes. H. N. Winn, J. T. Sprague, E. H. Grumke, and G. E. Oosterhous.

A talk on "The Women's Field Army" was given by Mrs. W. B. Noe.

Mrs. K. L. Puestow, Madison, was hostess to the members of the Dane County Medical Auxiliary on

December 14. Following a short business meeting, bridge was played.

Fond du Lac

Fourteen members of the Woman's Auxiliary to the Fond du Lac County Medical Society met at the home of Mrs. L. J. Keenan, Fond du Lac, on November 19. A dinner was served at 6:30 p. m. by Mrs. Keenan, assisted by Mmes. S. E. Gavin, C. W. Leonard and P. G. McCabe.

Roll call responses at the meeting were quotations from *Hygeia*. A donation was voted to the Children's Home Fund.

Miss Margaret K. Roberts, supervisor of the grades in the Fond du Lac schools, spoke on "To Know Your Neighbor."

Kenosha

The annual Christmas party of the Woman's Auxiliary to the Kenosha County Medical Society was held at the home of Mrs. A. M. Rauch, Kenosha, following a business meeting on December 1.

Mmes. P. E. Pifer, C. G. Richards, H. M. Ripley and A. L. Mayfield were the assisting hostesses for the party, at which gifts were exchanged among members and gifts for servicemen were collected to be given to the USO.

At the business meeting, plans were made to remember the Kenosha hospitals at Christmas. Mrs. G. C. Schulte is chairman of the committee in charge of this work. It was also decided to give a donation to the Wisconsin Association for Crippled Children. Mrs. A. L. Mayfield was named victory reporter to work with the Civilian Defense Council.

A musical program presented by Miss Dorothea Bach, pianist, and Miss Maryclare Ulrich, violinist, was enjoyed by members of the Kenosha County Auxiliary, meeting at the home of Mrs. W. H. Lipman, Kenosha, on January 5. Assisting hostesses were Dr. Helen A. Binnie, Miss Norabelle Binnie, Mrs. J. P. Graves and Mrs. J. H. Holm.

Miss Binnie spoke on civilian defense activities as described in the Victory Reporter's Bulletin. Mrs. A. M. Rauch read to the group an appreciative letter from a serviceman who had received one of the gifts sent by the auxiliary to the USO at Christmastime. Members voted to continue their drive to sell war bonds.

Mrs. H. M. Ripley presided at the table from which refreshments were served at the conclusion of the meeting.

La Crosse

The Woman's Auxiliary entertained members of the La Crosse County Medical Society on the evening of November 16 at Hunters' Lodge on Brice's Prairie near La Crosse. Following dinner, games were played and old-fashioned dances were called off.

Mrs. F. H. Wolf, president, was assisted in planning the dinner by Mmes. Gunnar Gundersen, R. C. Johnston and Martin Sivertson. The program was arranged by Mmes. J. C. Fox, J. F. Egan, and E. E. Seedorf.

Marinette

The annual holiday ball sponsored by the Woman's Auxiliary to the Marinette County Medical Society was held on Saturday evening, December 26, in the Crystal Room of the Hotel Marinette. Mrs. J. D. Zeratsky, auxiliary president, reports that more than 125 couples attended.

One of the high lights of the party was the introduction by Dr. J. D. Zeratsky of servicemen in attendance.

In previous years the proceeds from the ball were used to purchase *Hygeia* for schools in the city and county. This year the entire proceeds will be used for war emergency purposes.

Milwaukee

Members of the Woman's Auxiliary to the Medical Society of Milwaukee County held their December meeting in the afternoon of a day given over to war work and activities.

At 10 a. m., December 11, a course in home nursing was opened to them at the Visiting Nurses' Association Headquarters. At the same hour two units began work at the Pfister Hotel, one group sewing and making surgical dressings, the other rolling cotton for the Visiting Nurses' Association. No luncheon was planned, so the physicians' wives met in small groups for their lunch.

At 2 p. m., the auxiliary members were shown some unusually fine colored movies of Mexico by Mr. Robert Kohler, a Milwaukee photographer.

Dr. Edward H. Rynearson, specialist in internal diseases at the Mayo Clinic, Rochester, was a guest speaker at the luncheon meeting of the Woman's Auxiliary to the Medical Society of Milwaukee County on January 8 at the Y. W. C. A.

A question and answer period followed Dr. Rynearson's talk on the use and abuse of vitamins today. Members who attended reported that the discussion was extremely interesting and instructive.

Another speaker at this meeting was Mrs. E. J. Carey, national president-elect, who outlined the mid-year board meeting she attended in Chicago.

This meeting again followed a forenoon of war activities.

Outagamie

Twenty-six members of the Outagamie County Medical Auxiliary met at the home of Mrs. G. J. Flanagan, Kaukauna, for a buffet supper and meeting on November 19. The newly elected officers assumed their duties at this meeting. This auxiliary meets at St. Elizabeth Hospital, Appleton, on alternate Tuesdays to make bandages and assist the nurses.

Rock

Following a dinner at the Hotel Hilton, Beloit, the Woman's Auxiliary to the Rock County Medical Society was entertained by children from the Strong

School on November 24. Under the direction of Miss Emma Lundeberg, they presented a playlet, "The Message of the 1942 Christmas Seal."

When members of the Rock County Auxiliary met at the Janesville Women's Club for their annual Christmas party last month, they gathered around a table charmingly decorated with large pine cones and a modernistic wire Christmas tree resplendent in graduated tiers of twinkling candles. The lounge mantel was decorated with Yule greens, and a huge lighted tree near the fireplace added to holiday gaiety. Mrs. T. J. Snodgrass, president, conducted the business meeting that followed the dinner.

As Christmas projects the group packed jellies and cookies for the hospitals and provided gifts for servicemen and for patients at Pinehurst Sanatorium.

Mrs. H. E. Kasten reported that forty-three subscriptions to *Hygeia* had been taken in this auxiliary.

The matter of dues and membership of those whose husbands are in the armed forces was discussed, and it was voted that the dues of such members be paid by the organization for the duration.

The high light of the evening was the presentation by Mrs. W. A. Munn, Janesville, of the play, *The Corn is Green*, Ethel Barrymore's recent stage success.

Sauk

On November 12, members of the Auxiliary to the Sauk County Medical Society were entertained at dinner at the home of Mrs. H. A. Bachhuber, Sauk City.

The Sauk County Auxiliary met for dinner on December 10 at the Warren Hotel, Baraboo, and adjourned to the Elks Club for their business meeting. One new member was welcomed, and two were made service members.

Following the business meeting, Miss Myrtle Smith of the Sauk County Agriculture Office discussed rationing.

Sheboygan

When members of the Sheboygan County Medical Auxiliary met for lunch at Benedict's Heidelberg club on October 7, the nominating committee announced the new president-elect as Mrs. V. F. Neu, and the secretary–treasurer as Mrs. J. F. Kovacic. Mrs. G. J. Hildebrand is auxiliary president.

Later in the afternoon Mrs. H. J. Hansen of Sheboygan Falls, who has conducted courses in home nursing, described her work. Nurses' aide courses were discussed by Mrs. J. J. Boersma.

On December 2 this group met at Everetts Lodge for luncheon. Red Cross work was done in the afternoon.

Waukesha

Judge Allen D. Young was the speaker at a meeting of the Woman's Auxiliary to the Waukesha County Medical Society held at the home of Mrs. E. L. Lochen, Waukesha, on December 2. Judge Young reviewed the work being done by the juvenile court of Waukesha County and explained the program of crime prevention rather than punishment.

Following this talk, the business meeting of the auxiliary was conducted by Mrs. Lochen, the new president. The outline of the year's program for the various committees was discussed. Due to rationing regulations and additional duties connected with war work, the activities will be limited. Members voted to hold only four meetings this year, the remaining three to be held in April, June, and October.

As part of the group's philanthropic program, it was announced that in accordance with the boys' wishes, pictures would be taken of the boys at the Wisconsin Home and Farm School at Dousman and financed by the auxiliary.

Mrs. W. H. Oatway, program chairman, read a thought on Christmas by Prof. Arthur H. Compton of the University of Wisconsin.

The following committee chairmen were appointed by Mrs. Lochen:

Archives—Mrs. W. T. Murphy, Waukesha
Program—Mrs. W. H. Oatway, Waukesha
History—Mrs. J. B. Noble, Waukesha
Membership—Mrs. C. C. Edmondson, Waukesha
Philanthropic—Mrs. K. W. Doege, Oconomowoc
Hygeia—Mrs. F. L. Grover, Hartland
Social—Mrs. F. J. Woodhead, Mrs. F. M. Scheele, Waukesha
Press and Publicity—Mrs. F. W. Aplin

After the business meeting, dinner was served by Mrs. Lochen, assisted by Mmes. Oatway, Murphy, Woodhead, Edmondson and Aplin.

SOCIETY RECORDS

New Members

Samuel Plahner, Milwaukee.
E. F. Guy, Milwaukee.
A. J. Kampmeier, Milwaukee.
B. K. Lovell, Wauwatosa.
William Mautz, Eau Claire.
S. R. Ridley, Mineral Point.
G. F. Worm, Milwaukee.
P. A. Dier, Milwaukee.
J. A. Goodman, Milwaukee.
V. J. Kozina, Milwaukee.
R. W. Utendorfer, Mondovi.
J. A. Bonan, Milwaukee.
J. E. Hanko, Reedsburg.

Changes in Address

E. W. Miller, Colgate, to 231 West Michigan Avenue, Milwaukee.

J. L. Brizard, West Allis, to 805 South Fifth Street, Milwaukee.

R. R. Richards, Durand, to 422½ Bellinger Street, Eau Claire.

G. G. Drescher, Horicon, to Federal Correctional Institution, Englewood, Colorado.

H. E. Froede, Denver, Colorado, to 308 West North Avenue, Milwaukee.

R. H. Slater, Granton, to 401 Main Street, Stevens Point.

W. T. Casper, Newport, Rhode Island, to 2218 North 3rd Street, Milwaukee.

Society Proceedings

Brown—Kewaunee—Door

Dr. W. Eugene Wolcott, Green Bay, addressed members of the Brown–Kewaunee–Door Medical Society at their monthly meeting on December 10, at the Beaumont Hotel, Green Bay. He spoke on "The Role of the Intervertebral Disc in Back Pain."

Forty members were present at this meeting, and the following officers, all of Green Bay, were elected:

President—Dr. Wendell A. Killins
President-elect—Dr. Henry S. Atkinson
Vice-president—Dr. Robert W. Burns
Secretary–Treasurer—Dr. Erwin J. O'Brien
Delegates—Drs. Patrick R. Minahan, Oscar A. Stiennon
Alternate-delegates—Drs. William W. Kelly, Warren E. Leaper
Censor—Dr. James C. Colignon

The Brown–Kewaunee–Door County Medical Society held a dinner and business meeting at 6:30 p. m., January 14, at the Beaumont Hotel. John Wyeth and Brother, Incorporated showed a film on "Peptic Ulcer" prepared by the Department of Gastroenterology of the Lahey Clinic.

Calumet

At a meeting of the Calumet County Medical Society held on December 8 at Chilton, the following officers were elected:

President—Dr. John A. Knauf, Stockbridge
Secretary–Treasurer—Dr. John R. Goelz, Brillion
Delegate—Dr. Adolph C. Engel, New Holstein
Alternate-delegate—Dr. Peter J. Wollersheim, Forest Junction

Crawford

Dr. O. E. Satter, Prairie du Chien, secretary of the Crawford County Medical Society, reports that newly elected officers for the year are:

President—Dr. Herman L. Shapiro, Prairie du Chien
Secretary—Dr. O. E. Satter, Prairie du Chien
Delegate—Dr. Eli M. Dessloch, Prairie du Chien
Alternate-delegate—Dr. George R. Hammes, Seneca

Dane

When the Dane County Medical Society held its monthly meeting at the Madison Club on December 8, Dr. Karver L. Puestow of Madison delivered an illustrated lecture.

Douglas

Twenty members of the Douglas County Medical Society assembled at the Hotel Superior, Superior, on December 2 for their regular business meeting. Dr. Tuohy, a member of the staff of the Duluth Clinic, spoke to them on "Medicine in the Future."

The following new officers, all of Superior, were elected for 1943:

President—Dr. Henry A. Sincock
Vice-president—Dr. Elmer A. Myers
Secretary–Treasurer—Dr. Milton Finn
Censors—Drs. Arthur G. Wilcox, John C. Kyllo, James W. McGill
Advisory Committee—Drs. Herbert J. Orchard, William H. Schnell, Victor E. Ekblad, Loran W. Beebe
Public Relations Committee—Drs. Thomas J. O'Leary, Henry A. Sincock, Herbert J. Orchard, Stuart H. Perrin

The Douglas County Medical Society held its meeting at the Hotel Superior, Superior, on January 6 at 6:30 p. m. The special feature of this meeting was a movie and recording of normal and abnormal heart sounds.

Eau Claire—Dunn—Pepin

The Eau Claire–Dunn–Pepin County Medical Society held a dinner meeting at the Eau Claire Hotel on November 30. Thirty-two members and guests attended.

After dinner Dr. Theodore Rosen, Eau Claire, discussed the "Clinical Use of Blood and Plasma."

At a dinner meeting held at the 202 Club on Monday, January 25, Dr. Chester C. Schneider, Milwaukee, discussed "The Reduction of Disability in Fracture Management" and gave a practical demonstration of the use of adhesive in soft tissue injury.

Forest

At a recent meeting of the Forest County Medical Society, the following officers were elected:

President—Dr. Ernest G. Ovitz, Laona
Vice-president—Dr. Oscar S. Tenley, Wabeno
Secretary–Treasurer—Dr. Hector C. Marsh, Crandon
Delegate—Dr. Gordon E. Carroll, Laona
Alternate-delegate—Dr. Hector C. Marsh, Crandon

Grant

At a business meeting of the Grant County Medical Society held at the Municipal Building, Lancaster, on November 20, the following officers were elected for the coming year:

President—Dr. Ernest C. Howell, Fennimore
Vice-president—Dr. Harold W. Carey, Lancaster
Secretary–Treasurer—Dr. Hilton L. Doeringsfeld, Platteville
Delegate—Dr. James H. Fowler, Lancaster
Alternate-delegate — Dr. E. H. Spiegelberg, Boscobel
Censor—Dr. Elgie M. Houghton, Lancaster

Jefferson

Twenty-three members were present at the annual meeting of the Jefferson County Medical Society on December 17 at Shorecrest, near Jefferson, for the election of 1943 officers. Dr. E. A. Schoenecker, county secretary, writes: "Our attendance for the year was 70 per cent. With absences excused it ran to 78.7 per cent. We challenge any society to show a better attendance record!"

Officers elected are:

President—Dr. Felix H. Zimmerman, Watertown
Vice-president—Dr. Frank A. Gruesen, Fort Atkinson
Secretary–Treasurer—Dr. Oscar H. Hanson, Fort Atkinson
Delegate—Dr. Gustave E. Eck, Lake Mills
Alternate-delegate — Dr. Otto F. Dierker, Watertown

Kenosha

A meeting of the Kenosha County Medical Society was held at the Elks' Club, Kenosha, on December 8 at 7:30 p. m. There was no speaker. Election of officers was held, and the following Kenosha physicians were chosen:

President—Dr. Clifford M. Creswell
President-elect—Dr. Charles C. Davin
Secretary–Treasurer—Dr. J. P. Graves
Delegate—Dr. George C. Schulte
Alternate-delegate—Dr. W. C. Stewart

La Crosse

The La Crosse County Medical Society held a dinner meeting on January 19 at the Hotel Stoddard.

Dr. Karver L. Puestow, Madison, University of Wisconsin Medical School, spoke on "Diseases of the Gastro-Intestinal Tract."

Marathon

A meeting of the Marathon County Medical Society was held at the Hotel Wausau, Wausau, on December 8 at 6:30 p. m. A film on endocrinology was shown by Parke Davis & Company. The special feature of the evening was the induction of officers.

Milwaukee

Dr. Eben J. Carey, dean of the Marquette University School of Medicine, was installed as president at a meeting of the Medical Society of Milwaukee County on December 10.

Other officers elected are:

President-elect—Dr. John McCabe
Secretary—Dr. Robert McDonald
Treasurer—Dr. John Smith
Director—Dr. Carl Eberbach
Censor—Dr. Abraham B. Schwartz

Outagamie

The November meeting of the Outagamie County Medical Society was held at 6:30 p. m., November 19, at the American Legion Club House, Appleton. At this meeting annual committee reports were given.

Mr. Ben Kuechle of the Employers Mutual Insurance Co. at Wausau spoke on "The Physician's Responsibilities in the Proper Administration of the Compensation Law."

The December meeting of the Outagamie County Medical Society was held at 6:30 p. m., December 10, at the Conway Hotel. Dr. Marcos Fernan–Nunez, professor of pathology at the Marquette University School of Medicine, spoke on "A Medical Travelog of Spanish America."

The regular meeting of the Outagamie County Medical Society was held January 21 at 6:30 p. m. at the Conway Hotel. "Low Back Pain" was the subject discussed by Dr. R. H. Quade, Neenah.

Pierce—St. Croix

At a recent meeting of the Pierce–St. Croix County Medical Society, the following officers were elected:

President—Dr. Howard J. Laney, Prescott
Vice-president—Dr. Julius Blom, Woodville
Secretary–Treasurer—Dr. Chalmer Davee, River Falls
Censor—Dr. Joshua H. Armstrong, New Richmond
Delegate—Dr. Chalmer Davee, River Falls
Alternate-delegate—Dr. Otis H. Epley, New Richmond

Polk

A 7:00 p. m. dinner meeting was held on October 15 by the Polk County Medical Society at St. Croix Falls.

Dr. C. Donald Creevy, Minneapolis, Director, Division of Urology, University of Minnesota Medical School, spoke on "Carcinoma of Prostate and Treatment by Estrogens." He was the guest of Dr. L. O. Simenstad. Dr. William A. O'Brien, Minneapolis, Director of Postgraduate Medical Education, spoke on "Recent Advances in Preventive Medicine."

At the business meeting, the following physicians were elected:

President—Dr. Valentine C. Kremser, Amery
Vice-president—Dr. Raymond G. Arveson, Frederic
Secretary–Treasurer—Dr. George B. Noyes, Centuria
Delegate—Dr. Lien O. Simenstad, Osceola
Alternate-delegate — Dr. Karl F. Johnson, Frederic
Censors—Dr. Lorne A. Campbell, Jr., Clayton; Dr. Karl K. Ford, Amery; Dr. Henry J. Jeronimus, Osceola

Eighteen members of the Polk County Medical Society assembled in the Village Hall dining room on November 19 for dinner and a regular monthly meeting.

Racine

The following physicians were elected at the regular meeting of the Racine County Medical Society held on November 19:

President—Dr. William E. Buckley
President-elect—Dr. Gorton Ritchie
Vice-president—Dr. Hubert C. Miller
Secretary–Treasurer—Dr. Beatrice O. Jones
Delegate—Dr. T. C. Hemmingsen
Alternate-delegate—Dr. Edwin J. Schneller

A meeting of the Racine County Medical Society was held on Thursday, December 17, in St. Luke's Hospital library at 8:15 p. m.

A buffet supper for the members of the society was given by Drs. W. E. Buckley and R. J. Schacht at Dr. Buckley's home immediately following the meeting.

New officers were installed at a business meeting of the Racine County Medical Society which was held at the Racine Country Club January 20.

Richland

At a meeting of the Richland County Medical Society held on January 5 in the Richland Hospital, the following physicians, all of Richland Center, were elected to office:

President—Dr. Clause A. Sholtes
Vice-president—Dr. Richard E. Housner
Secretary—Dr. Gideon Benson

This is Dr. Benson's twenty-fifth year as secretary of the Richland County Medical Society. Dr. W. R. Coumbe, just retired, was made an honorary member.

Rock

At the November meeting of the Rock County Medical Society, Dr. William Mowry addressed the Society on the subject of "Common Allergic Problems."

Lieutenant Colonel Joel T. Deuterman of Camp Grant spoke on "War Surgery" and presented a film showing the treatment of various war gas poisonings to the members of the Rock County Medical Society at their December meeting.

Sauk

At a meeting of the Sauk County Medical Society, the following officers were elected for the year 1943:

President—Dr. Ernest L. Jewell, Loganville
Vice-president—Dr. Otto V. Pawlisch, Reedsburg
Secretary–Treasurer—Dr. John Booher, La Valle

Shawano

At a meeting of the Shawano County Medical Society held on December 8, the following officers were elected for 1943:

President—Dr. Earl E. Evenson, Wittenberg
Vice-president—Dr. Orville E. Damp, Birnamwood
Secretary–Treasurer — Dr. Frederick Bauer, Shawano
Delegate—Dr. Arthur A. Cantwell, Shawano
Alternate-delegate—Dr. Orlando F. Partridge, Mattoon
Censor—Dr. Lyndle W. Peterson, Shawano

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met at the Galesville City Hall, Galesville, January 14. Following dinner, Dr. Everett E. Seedorf, St. Francis Hospital, La Crosse, spoke on "X-ray Interpretation of Gastro-Intestinal Disorders." Ten members attended this meeting.

Winnebago

The Winnebago County Medical Society held a dinner meeting at the Athearn Hotel on December 3. The speaker for the evening was Dr. Otto Mortensen, Professor of Anatomy, University of Wisconsin Medical School. He lectured on "Surgical Anatomy of the Hand." His talk was illustrated with dissected anatomic specimens of the hand, lantern slides, and motion pictures showing practical applications of anatomic facts with special emphasis on the treatment of infection.

Officers for the following year are:

President—Dr. Vincent G. Springer, Omro
Vice-president—Dr. Gerhard R. Anderson, Neenah
Secretary–Treasurer—Dr. Henry A. Romberg, Oshkosh

A program arranged by the psychiatric clinic committee of the Winnebago County Medical Society was presented at the dinner meeting of the society held January 7 at 6:30 p. m. at the Valley Inn Hotel, Neenah. The committee consisted of: Dr. Byron J. Hughes, Dr. Ethan B. Pfefferkorn, and Dr. Frank O. Brunckhorst. Dr. Elizabeth Kane of the Bureau of Maternal and Child Health of the Wisconsin State Board of Health spoke on the psychiatric clinics held in Winnebago County.

Wood

The Wood County Medical Society held its winter meeting at the Hotel Charles, Marshfield, December 17. Following the dinner at 6:30 p. m., a scientific program was presented. Dr. E. J. McGinn, Marshfield, spoke on "The Use of Hormones in Gynecology." "Medical Procurement" was the topic given by Dr. H. H. Christopherson. "Case of Pneumothorax Associated with Pneumonia" was given by Dr. Leland Pomainville.

News Items and Personals

C. N. NEUPERT

Dr. Carl N. Neupert was elected by the State Board of Health as the State Health Officer on January 8.

For the past seven years Dr. Neupert has served as Assistant State Health Officer. Before his association with the State Board of Health, he was a practicing physician at Janesville for ten years, specializing in pediatrics. He served as secretary of the Mercy Hospital staff in Janesville and was at one time secretary of the Rock County Medical Society.

Special postgraduate training was taken by Dr. Neupert in the field of public health. He received his Master's degree in public health at the University of Michigan in 1941.

The opportunity of close association with the former State Health Officer will make it possible for Dr. Neupert to continue, without interruption, the activities of the State Board of Health.

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Dr. Robert H. Slater has accepted a position with the Dr. Rice Clinic in Stevens Point. He was formerly associated with *Dr. Russell Rath* in the Rath Clinic.

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At the annual staff meeting of St. Mary's Hospital, Milwaukee, held January 6, the following physicians were elected to the staff:

Chief-of-Staff—*Dr. Robert J. Bach*
Vice-president—*Dr. William M. Jermain*
Secretary–Treasurer—*Dr. Alvin D. Kilian*

—△—

On January 7, the following physicians were elected to the staff of the Bellin Memorial Hospital, Green Bay:

President—*Dr. Wendell A. Killins*
Vice-president—*Dr. Robert M. Kispert*
Secretary–Treasurer—*Dr. Frederick O. Kuehl*

—△—

Meat rationing should not cause a hardship *Dr. Elmer L. Sevringhaus* of the University of Wisconsin Medical School and May S. Reynolds of the home economics department said at a roundtable discussion during a meeting of Madison public school teachers in the Board of Education building Tuesday, November 24. The meat allocation under rationing will be two and a half pounds per week for each adult, three-fourths of a pound for each child under six years, and one and a half pounds for each child from six to twelve years. The meat allowance includes the bone and fat.

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At a meeting of the Kiwanis Club held at Hovland's Cafe, *Dr. Stephen E. Williams*, Chippewa Falls, showed moving pictures of countries where the war is now raging. These pictures were taken by the doctor on his cruise several years ago.

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Dr. John T. Murphy, Green Bay, honorably discharged from army service, is the first veteran of World War Two to be accepted into membership by Sullivan Post No. 11 of the American Legion. He was injured while on duty with the Fifth Division Ski Patrol at Camp McCoy during the winter of 1940–41.

—△—

Dr. Lemuel D. Smith, Milwaukee, was host at a Christmas party to sixty young folk who had been his patients during the last year. The Christmas party has been an annual event for five years.

—△—

Dr. Willard O. Dehne was elected president of the medical staff of St. Elizabeth Hospital, Appleton. The following physicians were also elected to the staff:

Vice-president—*Dr. Milo E. Swanton*
Secretary—*Dr. Willard E. Archer*

—△—

The Kiwanis Club and members of Theda Clark Hospital nursing staff honored *Dr. Harold L. Baxter*, former Neenah physician who is a lieutenant in the United States Navy, at a dinner on Thursday, December 10. Dr. Baxter was commended by his commanding officer for conduct in the battle in which the cruiser Boise was severely damaged.

—△—

Dr. Herschel C. Danforth, Janesville, was featured on "Victory Is Our Business," the quarter-hour program broadcast by WCLO at 2:00 p. m. and 6:30 p. m. on Thursday, December 10. Dr. Danforth, plant physician at the Janesville plant of the Oldsmobile division of General Motors, told of his contribution to the war effort.

Dr. John M. Grinde, Waunakee, honorably discharged from army service, accepted a position as surgeon on the staff of the Permanenete Foundation Hospital in California.

—△—

Dr. Harold E. Marsh has been appointed village health officer of Maple Bluff.

—△—

Waupun physicians and dentists held a 6:30 p. m. dinner meeting December 17 in the Hotel Waupun. "Work of a City Nurse" was the topic given by Miss Leone Norton, city nurse.

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Dr. Marshall W. Meyer, Ashland, was guest speaker at the Washburn Hospital Auxiliary meeting held January 13. He spoke on "Communicable Diseases."

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Dr. Harold Helm, Beloit, spoke before the Rotarians January 12 on "Some Early Beloit Doctors." The present-day transportation problems set the stage for this talk.

—△—

The Manitowoc Lions Club met Tuesday evening, January 5. The speaker, *Dr. Norman C. Erdman,* a member of the Lions club and a former local physician, spoke on the use of sulfa drugs. Dr. Erdman discussed vitamins and summarized the contributions of medical science to the war effort.

—△—

Dr. Charles W. Henney was elected president of St. Savior's General Hospital, Portage. *Dr. James W. MacGregor,* former vice-president, left for San Diego, California, to begin his active service in the United States Navy. His position is being filled by *Dr. Edward F. Tierney,* while *Dr. Harry E. Gillette,* Pardeeville, is the new secretary–treasurer.

—△—

Dr. William D. Stovall, Madison, spoke on "Women's Interest in Cancer Research," and *Dr. Arnold Jackson,* Madison, spoke on "Nerves and Working Women," to the Business and Professional Women's Club at their dinner meeting at the Women's Building on January 7.

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Dr. Malcolm P. Andrews, Manitowoc, was one of eight speakers at the Farm Mobilization Day program. He urged the farmers to do their utmost to meet increased production goals. He illustrated his lecture by applying the phrase, "Praise the Lord and Pass the Ammunition," to farmers as well as fighting men. The farmers ammunition is food, the most important in the world.

—△—

Dr. Charles H. Feasler, formerly senior physician at the Winnebago State Hospital, has joined the staff of the Rogers Memorial Sanitarium at Oconomowoc.

—△—

Dr. Owen C. Clark, formerly on the staff of Rogers Memorial Sanitarium, has been commissioned a first lieutenant in the Medical Corps, United States Army Air Force, and is at present in officer's training school at Miami Beach, Florida.

—△—

The eighth annual Lippitt Memorial Lecture under the auspices of Mount Sinai Hospital, Milwaukee, presented Dr. M. L. Sussman at the Marquette University School of Medicine's auditorium Friday, January 22 at 4:30 p. m. Dr. Sussman, director of the Department of Radiology, Mount Sinai Hospital, New York, spoke on "Newer Concepts in the Diagnosis of Congenital Heart Disease."

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Dr. Elmer L. Sevringhaus presided at the dinner-lecture of the University Club held on Thursday, December 3. The results of approximately twelve years' research on Vitamin B were described by Dr. C. A. Elvehjem, professor of biochemistry at the University of Wisconsin.

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Dr. Sarah Rosekrans, Neillsville, is associated with Dr. Sidney D. Anderson in a clinic at Grayslake, Illinois. She was a practicing physician in Neillsville for the past thirteen years, besides being active in civic developments and social life of the city.

—△—

Dr. Donald R. Searle was elected president of the staff of St. Mary's hospital at its meeting Monday, December 28. *Dr. Victor Ekblad* was reelected to the office of vice-president, while *Dr. Thomas J. Doyle* was elected secretary.

—△—

The ninth annual meeting of the Wisconsin Academy of Surgery was held at the University Club, Milwaukee, January 27. The dinner at 6:00 p. m. was followed by a business meeting. At 7:30 p. m. *Dr. James Garland,* Milwaukee, spoke on "Carcinoma of the Breast," and *Dr. Lemuel D. Smith,* Milwaukee, discussed "The Stader Reduction Splint."

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The Milwaukee Neuro-Psychiatric Society met on Thursday, January 28, at the University Club. Dr. Paul J. Schrader, Missouri, spoke on "Treatment of 180 Cases of Nervous and Mental Disorders by Prefrontal Lobatomy."

—△—

Dr. Leland Pomainville, Wisconsin Rapids, was one of several speakers at the Elks' Luncheon Club, Tuesday, November 24. He spoke on "Why We of the Medical Profession are Thankful this Thanksgiving." A recording was made and broadcasted over WFHR on Thanksgiving Day.

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On December 3, *Dr. Andrew L. Banyai,* Muirdale Sanatorium, Wauwatosa, spoke at the West Allis Medical Society, West Allis. His subject was "Nontuberculous Pulmonary Infections."

—△—

The Milwaukee Academy of Medicine held its election at a dinner meeting at the University Club, Tuesday, January 19. *Dr. Edwin Henes, Jr.,* former

secretary of the International Postgraduate Medical Association, was chosen president-elect. *Dr. Frederick W. Madison* is vice-president. *Dr. Elwood Mason* was reelected secretary, and *Dr. Irwin Schulz* treasurer. *Dr. Walter P. Blount* was nominated for librarian to fill the vacancy caused by the enlistment of *Dr. Maurice Hardgrove* in the army medical corps as a major. *Dr. Theodore L. Squier* was inducted as president. *Dr. William B. Campbell,* Waukesha, was given an honorary membership because of being a nonresident member for forty years.

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At a staff meeting of the Wisconsin General Hospital on December 15, *Dr. Wellwood M. Nesbit* spoke on "Common Office Procedure in the Practice of Ear, Nose, and Throat." On January 5, *Dr. Chester M. Kurtz* spoke on "Cardiac Problems for the General Practitioner." On January 19, *Dr. William H. Oatway* and associates gave a symposium on tuberculosis. On January 26, *Dr. Robert E. Burns* spoke on "Backache." On February 2, *Dr. Elmer L. Sevringhaus* spoke on "The Rudiments of Managing Diabetes and Obesity."

The first regular meeting of the Milwaukee Oto-Ophthalmic Society was held on November 10 at the University Club with dinner at 6:30 p. m. The scientific program consisted of three reports: (1) Presentation of Two Case Reports, Thomas J. Naughton, M. D.; (2) Vernal Conjunctivitis, Herman A. Heise, M. D.; (3) Treatment of Tuberculosis of the Eye, Herbert F. Hawssler, M. D.

BIRTHS

A son to Dr. and Mrs. Thomas Walsh, Sauk City, on January 6.

A daughter, Carol Mary, to Dr. and Mrs. John J. Sazama, Bloomer, on December 30.

A son to Dr. and Mrs. Rolf Quisling, Madison, on January 11.

A son, Richard Everett, to Dr. and Mrs. Everett E. Seedorf, La Crosse, on October 30.

MARRIAGES

Lieutenant Henry Longfellow, Camp Leonard Wood, and Dr. Helen Bane, Madison, on December 9 at Brainard, Minnesota.

DEATHS

Dr. Clemens Bossard, 80, a retired Richfield physician, died while riding a Milwaukee city bus.

He was born in Herman, Sheboygan county. After taking premedical work at Lawrence College and graduating from Rush Medical College and Hahnamann College, Chicago, Dr. Bossard practiced in Milwaukee and then in Richfield.

He is survived by a son, two sisters, and a brother.

Dr. Bedan Alwoth Cole, 85, died at his home in Thorp on December 15. Dr. Cole was reported to be the oldest practicing physician in the state at the time he retired because of ill health two years ago. He attended medical college at Iowa City, Iowa, and the Hahnamann Medical College in Chicago, from which he graduated February 20, 1883.

He is survived by his widow, four daughters, and a son.

Dr. Oliver M. Layton, 72, died suddenly at his home December 27. Dr. Layton was born in Maysville, Kentucky, and was graduated from Rush Medical College in Chicago. He was affiliated with the Wiley–Smith clinic of Fond du Lac.

Dr. Layton was a member of the Fond du Lac County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving, besides the widow, are a son and two daughters.

Dr. Grove Harkness, 82, of Waukesha, died in Milwaukee December 12 after an illness of three weeks. He was one of Waukesha's oldest physicians and a prominent figure in the city for fifty years.

Dr. Harkness was born in Lafayette township and was graduated from Rush Medical College. His father, Dr. Daniel Harkness, was one of the first practicing physicians in the county, and his mother, Harriet Whitmore Harkness, was the first white child born in the township of Lafayette.

At the time of his death, Dr. Harkness was a member of the Waukesha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow.

Dr. George R. Ernst, 73, retired superintendent of the Milwaukee health department, tuberculosis division, died December 3.

He was a graduate of Northwestern College at Watertown and of Rush Medical College. He also received a degree from the London Royal College of Physicians and became a member of the Royal College of Surgeons of England. In 1909 he returned from Europe to become chief of the Blue Mound Sanitarium and the Children's Preventorium.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, a daughter, two brothers, and two sisters.

Dr. George W. Neilson, 60, widely known physician in Milwaukee for thirty-three years, died December 1, following an illness of a year.

He was born in Milwaukee and graduated from the Marquette University School of Medicine. Dr. Neilson served as a major in command of a field hospital in France during the First World War.

At the time of his death, Dr. Neilson was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors are his widow, a daughter, his mother, four brothers, and a sister.

Dr. Hervie A. Dobson, 100, Dane County's last Civil War veteran, died November 27.

Born in New York, Dr. Dobson enlisted in the Union Army by the special permission of President Lincoln. Following the war, he entered George Washington University and received his medical degree. For the next fifty-seven years he was a special agent and investigator for the United States treasury department.

He is survived by two sons and a daughter.

Dr. Frank C. Sarazin, 72, a physician in Superior for fifty years, died December 17 after a brief illness.

Dr. Sarazin had been chief surgeon for the Mesabi division of the Great Northern railroad for many years and was a member of the Railway Surgeons of America.

He was a member of the Douglas County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving are three sons, four daughters, two brothers, and a sister.

Dr. Perry T. Walters, 38, prominent La Crosse physician, died January 8.

He was a graduate of the University of Michigan Medical School and Minneapolis General Hospital where he specialized in eye, ear, nose and throat.

Dr. Walters was a member of the La Crosse County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He would have been commissioned a major in the Wisconsin base hospital army unit, which is to be activated soon.

Dr. Walters is survived by his widow, three sons, two sisters, and his mother.

COMING EVENTS

Wisconsin General Hospital Staff Meetings For 1943

These meetings are held in the Auditorium of the Service Memorial Institute. Attendance is restricted to third and fourth year medical students, internes, residents, hospital and medical school faculty, and interested outside physicians.

February 23—Dr. I. R. Sisk: The Etiology and Treatment of Renal and Ureteral Stones

March 16—Dr. J. E. Gonce: Some Aspects of Urinary Infection in Infancy and Childhood

March 23—Dr. C. S. Harper: Office Gynecology

April 6—Dr. R. E. Campbell: Carcinoma of the Uterus

April 20—Dr. K. L. Puestow: Sigmoidoscopic and Radiologic Correlation in Diagnosis and Treatment of Colonic Disorders

May 4—Dr. E. A. Pohle: Indications and Contraindications for Roentgen Therapy

May 18—Dr. L. W. Paul: Fundamentals of Gastro-Intestinal X-Ray Diagnosis

CORRESPONDENCE

January 20, 1943

Mr. C. H. Crownhart, Managing Editor
Wisconsin Medical Journal
Madison, Wisconsin

My dear Mr. Crownhart: May I congratulate you as a fellow editor upon the recent special issue of your *Journal?* This constitutes a very complete and valuable contribution to American "official" medical publications, and, I trust, will meet with deserved attention.

With best wishes,

Sincerely yours,
(Signed) George W. Kosmak, M. D.
Editor
American Journal of Obstetrics and Gynecology

January 25, 1943

C. H. Crownhart, Esq., Secretary,
The State Medical Society of Wisconsin,
Madison, Wisconsin

Dear Mr. Crownhart: I have just received my copy of the January, 1943, issue of *The Wisconsin Medical Journal*, being The 1943 Blue Book of The State Medical Society of Wisconsin. I cannot conceive of a greater service that you could render the medical profession and the people of Wisconsin than the service you have rendered by this publication. Its fullness and accuracy amaze me. The members of the Society can find an abundance of medical information elsewhere than in their *Journal*, but nowhere outside The Medical Blue Book can they find in a conveniently accessible form the information you have given them there, much of which must guide them every day of their professional lives.

I congratulate you and the medical profession of Wisconsin.

Very sincerely yours,
(signed) Wm. C. Woodward, M. D.
2701 Connecticut Avenue
Washington, D. C.

MOTION PICTURE CATALOGUE LOAN PACKETS AVAILABLE

The secretary's office, in collaboration with the Council on Scientific Work, has brought together the available catalogues of scientific motion pictures.

Secretaries and program chairmen of county medical societies will find these loan packets valuable to them in arranging county medical society programs. A wide variety of films is available embracing such subjects as obstetrics and gynecology, surgery, and other branches of medicine.

These packets may be obtained by writing the secretary's office, 917 Tenney Building, Madison, Wisconsin.

ENDURING CHARACTER

SIXTY-SEVEN YEARS—TIME TO TRAIN SUCCEEDING CROPS OF YOUNG MEN IN LILLY TRADITIONS—TIME TO ESTABLISH A SOLID FOUNDATION ON A POLICY THAT IS STRIKINGLY LIKE THE GOLDEN RULE.

ELI LILLY AND COMPANY
INDIANAPOLIS, INDIANA, U. S. A.

FOR THE PHYSICIAN'S PRESCRIPTION Lilly

Buy War Bonds

News of the Neighbors

Indiana Industrial Health Committee

The Indiana State Medical Association feels that its new Committee on Industrial Health is the most important and the most vital committee of its entire list. To quote from *The Journal of the Indiana State Medical Association:* "Since the enaction of laws in many states relating to compensation for occupational diseases, the matter has assumed much greater importance and the medical profession has come to realize that it has an important role to play in the drama. Not only do we have to do our part, but we must be on the alert to see to it that 'our rights'—if we have any—are preserved. We want to give all in our power to further this valuable addition to industrial economics, at the same time we want to be certain that we still maintain control over the purely professional phases of the various problems presented.

". . . Industry wants help, and that help will have to be had from one of two sources, either from the state medical groups, or from the United States Public Health Service—we much prefer that the medical profession write their own ticket in this matter!"

Indiana Asks a "Pay as You Go" Policy

The following is quoted from the December, 1942, issue of *The Journal of the Indiana State Medical Association:*

"The *Ligonier Leader,* under date of October 28, has the following editorial comment to make on a matter of great interest to every member of the medical profession. We are quite in accord with the idea, there being no good reason why medical bills should not receive the same attention as grocery and market accounts, etc.

" 'American doctors are beginning to include with their monthly statements to patients a small printed card asking that medical attention be paid for on a strictly cash basis. 'We ask your cooperation because of increasing difficulty of bookkeeping facilities.'

" 'The wording is dignified and courteous and touches upon only one of many emergencies confronting the medical profession today—that of office help. This is especially true in communities where essential industry is taxing man and woman power to the breaking point.

" 'The doctors' problems are legion; war is taking from civilian life the bulk of the younger medical men, and remaining older doctors are overwhelmed with work. The doctors remaining in home service fully realize their responsibility for maintaining civilian health during this critical period.

" 'Let us not forget that our family doctor is an integral part of an American tradition, and that this tradition has been built, through the years, upon his personal gifts as an individual; upon his integrity, and his character.

" 'Let's pay as we go—and stand by.' "

New York's Older Physicians "Eager to Learn"

Physicians in the older age groups who are left at home during the war to care for civilian needs are on their toes to learn the new developments in medicine, according to the mid-month issue of the New York State Journal of Medicine, published December 15.

Comparison of attendance this year with last at district branch meetings of the Medical Society of the State of New York, covering the entire state and comprising postgraduate educational activities, shows, according to the Journal, that "bald and gray heads seemingly will carry on to the limit of their ability, always eager to learn that they may better serve."

In 1941, the attendance at corresponding meetings of physicians between forty-five and fifty-four years of age consisted of 25.21 per cent of the total; in 1942, 30.81 per cent. From fifty-five to sixty-four years: 16.15 per cent in 1941; 22.56 in 1942. Among those sixty-five to seventy-four: 9.79 per cent in 1941; 15.66 in 1942. In the group seventy-five to eighty-four: 1.56 per cent in 1941; 2.53 in 1942.

WHO ARE THE MEN BEHIND THE "FACTS"

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FACTS quoted by PHILIP MORRIS are based on studies conducted by recognized authorities whose work is known to the profession...whose findings have been published in leading medical journals.*

Their tests, not only in the laboratory, but in the clinic as well, have conclusively *proved* PHILIP MORRIS Cigarettes to be *definitely and measurably less irritating* to the sensitive tissues of the nose and throat . . . an advantage due to a difference in the *manufacture* of PHILIP MORRIS.

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* *Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

Between eighty-five and ninety-four, one physician turned out each year.

"The interest and alertness of those over sixty-five is notable," states the Journal. "They allow no grass to grow under their feet; they were on deck both this year and last to learn what was new and to signify their willingness, even eagerness, to bear their share of the burden and heat of the day—and the night, too, if need be."

Ohio Asks For Lower Medical Fees

The November issue of *The Ohio State Medical Journal* carries the following quotation from *Newsweek*, October 12, and heads it "Let's See To It That This Does Not Happen in Ohio!"

" 'Public-health authorities are worrying over an unexpected headache brought on by wholesale induction of doctors by the armed forces. Naturally, the young and single men were taken first. These, because their practices were still to be built up, usually kept their fees low to cater to the less affluent. Recent surveys show that those now left behind to care for civilians are generally long-established older men or specialists, both of whom receive higher fees. Consequently, the poorer classes, deprived of cheap medical advice and unable to pay the higher fees of the older doctors, have been forced to turn to the already overburdened public-health services,' or do without medical care."

Trade News

Medical Science Holds Important Key to Victory

Pointing out that disease killed more soldiers than did bullets during past wars, Dr. Harvey C. Rentschler asserted that in the current world war, medical science hopes to reduce such casualties perhaps to a lower percentage than that of actual combat.

"The side that achieves this goal will hold a tremendous advantage," said Dr. Rentschler, noted physicist and Director of Research at the Lamp Division of the Westinghouse Electric and Manufacturing Company, Bloomfield, N. J.

"Medicine, however, is but one field where we need men trained in basic sciences to help win the war," he declared. "The knowledge of electronics is vital to the construction of detecting and signalling devices. Chemistry brings us synthetic rubber; metallurgy provides essential substitute metals, and there are many other important sciences doing great work today."

Dr. Rentschler discussed the war role of basic scientific research at Ursinus College where he was awarded the honorary degree of Doctor of Laws by Dr. N. E. McClure, president of the college, at a founder's day ceremony.

Now completing his twenty-fifth year as Director of Research at the Westinghouse Lamp Division, Dr. Rentscher has won fame for his work on photocells, roentgen ray, and other electronic tubes, ultraviolet radiation and in related fields of science.

Outstanding among his achievements has been the development of the Sterilamp—the slender, rod-shaped lamp that produces short wave ultraviolet rays deadly to air-borne and surface bacteria. Approved by the American Medical Association, more than 150,000 of these microbe killers are at work today in hospitals, nurseries, industrial plants, offices and homes to guard against spread of disease.

War Production Board Order Affects Vitamin Capsules

To conserve vitamin A supplies during wartime, W. P. B. order L–40 limits the content of capsules to 5,000 vitamin A units.

In compliance with this order, capsules of Mead's Oleum Percomorphum 50 per cent with Viosterol now contain 83 mg. of oil, equivalent to 5,000 vitamin A units and 700 vitamin D units per capsule.

The new size capsule is now supplied in boxes containing forty-eight and 192 capsules—about twice the number of capsules without increase in price.

R C. Brewster to Head Sales For Frederick Stearns

Appointment of Rafael C. Brewster as general salesmanager in charge of sales and advertising for Frederick Stearns and Company is announced by Erwin F. Fauser, president.

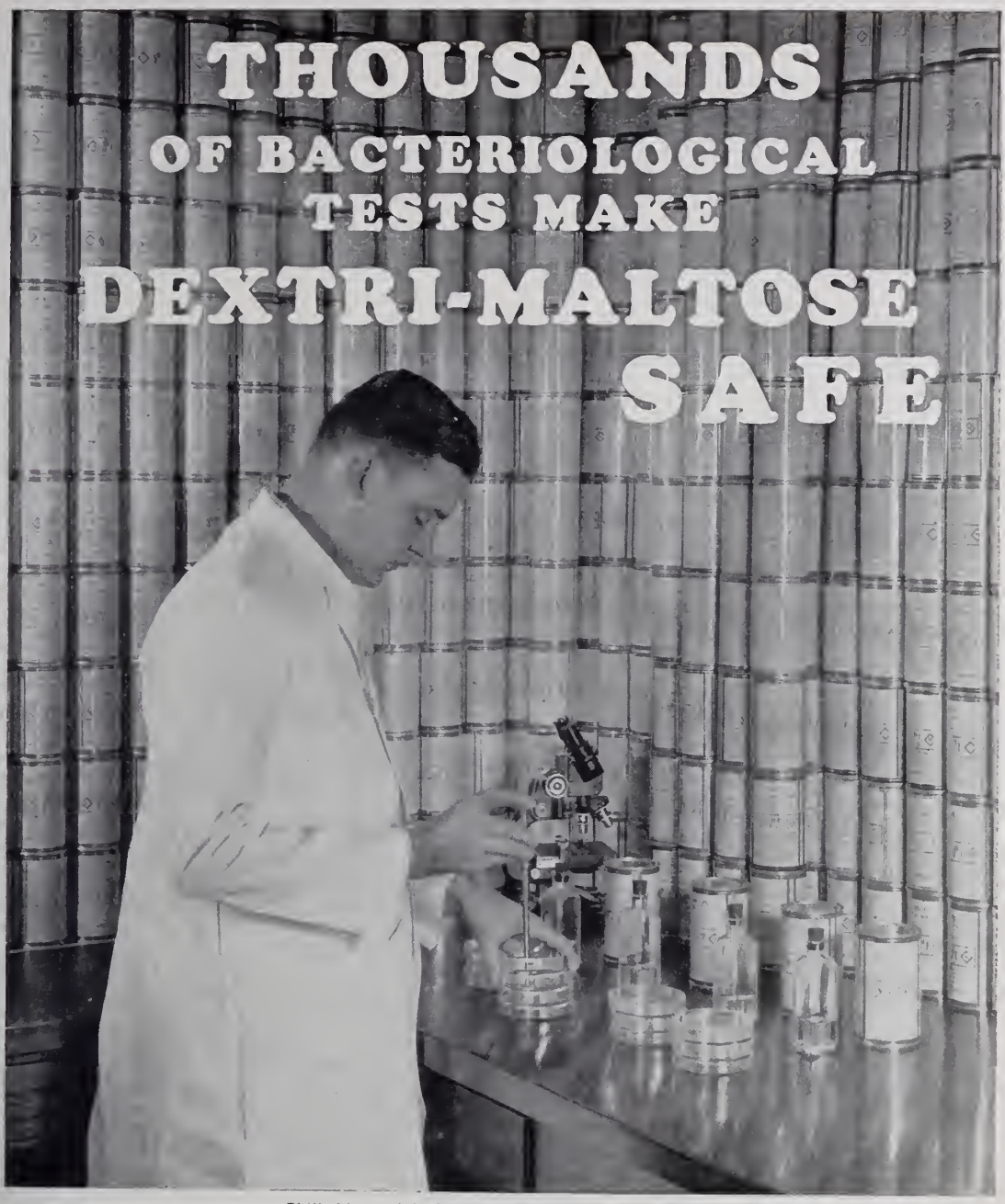
Brewster's wide experience includes sales direction for E. R. Squibb and Son, Lentheric, Inc., House of Westmore, Inc., and Canada Dry Ginger Ale, Inc. He also has been a member of two advertising agencies and of the staff of Cosmopolitan Magazine.

His appointment, President Fauser said, is in line with Stearns' program of expansion of research and products.

Vitamin Films in Color

During the past year, the three 16 mm. silent motion pictures in color, describing certain vitamin

THOUSANDS OF BACTERIOLOGICAL TESTS MAKE DEXTRI-MALTOSE SAFE



Skilled bacteriologists constantly test Dextri-Maltose

THOUSANDS of samples of Dextri-Maltose, secured both during the course of manufacture and after packing, are continually analyzed bacteriologically. This close correlation between laboratory and factory results in a product having a remarkably low bacterial count—well under 100 per gram. A quarter of a century of clinical success has demonstrated that such ceaseless vigilance is indispensable to safety. Here, where the life and health of the infant and the reputation of the physician are in the balance,—VALUE, NOT PRICE, IS THE TRUE MEASURE OF ECONOMY.

SANITARY CONTROL OF DEXTRI-MALTOSE . . . (NO. 2 OF A SERIES)

Please enclose professional card when requesting samples of Mead Johnson products to cooperate in preventing their reaching unauthorized persons
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Prescribe Journal-advertised products and you prescribe the best.

deficiency diseases, which were made available by Eli Lilly and Company, Indianapolis, for showing before medical groups under sponsorship of a physician, have been in continuous demand. One film deals with deficiency of thiamine chloride (beriberi), another with nicotinic acid deficiency (pellagra), and the third with ariboflavinosis. To meet increasingly frequent demands for the films, additional new prints have been placed in circulation and are now ready for loan. The major part of all films concerns the clinical picture presented by the patient with reference to treatment by diet and specific medication. They do not contain advertising of any description, nor is the name of Eli Lilly and Company mentioned.

The films were made at the Nutrition Clinic of University of Cincinnati at the Hillman Hospital, Birmingham, Alabama, where studies were initiated in 1935, under the joint auspices of the Department of Internal Medicine of the University of Cincinnati and the University Hospitals of Cleveland. Subsequently, these investigations became a cooperative project between the Departments of Medicine of the University of Cincinnati and the University of Alabama, and the Department of Preventive Medicine and Public Health of the University of Texas.

Atabrine

America is prepared today to meet the challenge of malaria, which may yet menace all the world, according to Dr. Morris Fishbein, editor of *The Journal of the American Medical Association.*

In a paper specially written for presentation when the Winthrop Chemical Company received the Army–Navy "E" at twin ceremonies in Rensselaer, New York, and New York City, Dr. Fishbein traced the history of the development of Atabrine, a synthetic substitute for quinine in the treatment of malaria, which is now nullifying Japanese conquest of the quinine producing Dutch East Indies.

"The story is one of the great dramas of medical achievement," Dr. Fishbein declared. "But the end is not yet. Many a man will come home from the war infected with malaria. We in our country will control its spread.

"For the needs of the people and the warriors of the United Nations, this country alone will soon be producing enough American Atabrine to treat 106,000,000 cases of malaria. But with malaria threatening one-third of all of the population of the world, the figures need not stagger us.

"When American medicine began to prepare for war as early as June, 1940, we were assured that we had enough quinine to last for three years. Then came Jap Sunday at Pearl Harbor, the invasion of the Netherlands East Indies, upon which we and our allies depended for continuing supplies; then came the cry from Great Britain and from the magnificently fighting Russians battling in the Caucasus—rife with malaria—for more and more drugs to cope with this body-shattering disease.

"From the Philippine Islands and from Bataan came the reports from our own soldiers, our fliers, even our doctors and nurses trembling with the fever and chills caused by the vicious malarial parasite. And the news meant to those who could see ahead the need for more and more quinine, more Atabrine.

"The defeat at Bataan has been in some places charged to malaria and to a shortage of quinine. Let us realize first that quinine alone could not have saved the situation. They needed airplanes, food, clothing, munitions and men in addition to antimalarials. For purposes of drama, quinine may, however, well be the hero of the situation.

"The launching and mass production of a new drug is a far cry from the test tube experiment in the laboratory. There was, of course, German Atabrine, but as we learned in World War I it is quite a step from a German product, a German formula, or German patents to reproduction of the product for use in our country.

"That is the task to which Dr. A. S. Sherndal, plant superintendent, and all workers of the Winthrop Chemical Company, turned their attention. The call came from the National Research Council; from the Office of Scientific Research and Development; from the United States Public Health Service; from the people of Brazil, Chile, the Argentine, from Cuba, Porto Rico, Mexico, Peru, Uruguay, Colombia, where stocks of German supplied drugs began to run low.

"The laboratory problem was translated to the factory, the difficulties of priorities and transport were overcome; the workers were secured and instructed in their tasks, and the wheels began to roll.

"But even yet the problem was not fully answered. Airplanes brought back from many places in South America original unopened packages of German Atabrine. The contents were tested in the laboratories by pharmacologists and chemists against the Winthrop Atabrine. They were tested in hospitals and in Army and Navy installations on healthy and on sick men against the American Atabrine. And in all these tests the American Atabrine got that marvelous sign that means so much to any American—the simple two syllable reward of merit—O. K."

Sterling Drug Announces Merger

A merger of two companies in the field of ethical pharmaceuticals (drugs dispensed largely on physicians' prescriptions) was announced January 5 by James Hill, Jr., president of Sterling Drug Inc., of which both are affiliates.

Under the merger, Winthrop Chemical Company, Inc. has absorbed Alba Pharmaceutical Company, Inc., and has taken over Alba's assets, property, trademarks and good will.

As a result of the merger, Fairchild Brothers and Foster, a wholly-owned subsidiary of Alba, has become a wholly-owned subsidiary of Winthrop.

Alba Pharmaceutical Company was incorporated in New York on August 30, 1935.

Tuned to VICTORY

Uhlemann—
RUSH—FOR VICTORY

The above is an enlargement of a red, white and blue label to be applied exclusively to prescriptions for Victory Workers—to speed production on their glasses.

The part we both play, Doctor, is to give visual accuracy and eye-comfort to those in industry doing Victory Work.

Therefore, any prescription bearing this label will be given service preference in our laboratories.

We are sure you, and your patients not directly affiliated with Victory Work, will approve.

Obtain your supply from

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BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

The Care of the Aged. (Geriatrics) By Malford W. Thewlis, M. D., attending specialist, general medicine, United States Public Health Hospitals, New York City; attending physician, South County Hospital, Wakefield, R. I.; special consultant, Rhode Island Department of Public Health. Ed. 4, thoroughly revised. Cloth. Price, $7. Pp. 589, illustrated. St. Louis: C. V. Mosby Company, 1942.

The fact that it has been necessary to issue a fourth edition of this work is an indication of the growing importance of the care of the aged from the medical viewpoint. The author's statement, "The census of 1940 shows that there are over 8,956,000 persons over sixty-five years of age—an increase of 35 per cent over this age group in 1930," is also an indication.

Bringing in the use of the sulfonamide drugs is perhaps the chief addition of the revision.

The author's method of narrative case citation throughout the book is of interest.

His two points of keeping the aged patient occupied and out of bed whenever possible are most significant.

Geriatrics is after all the application of good medicine to the individual patient, in this case the aged patient. H. M. C.

Military Surgical Manuals. Volume II. Ophthalmology and Otolaryngology. Prepared and edited by the subcommittees on ophthalmology and otolaryngology of the committee on surgery of the division of medical sciences of the National Research Council. Cloth. Price, $4. Pp. 331, with 124 illustrations. Philadelphia: W. B. Saunders Company, 1942.

This volume is one of a series which has been prepared to supply the United States Army and Navy Medical Departments reliable council information in the field of military surgery.

The compendium was written for nonspecialists in the field of ophthalmology and otolaryngology. It was prepared by a group of highly qualified specialists in these branches of medicine to serve as a guide for the general physician and surgeon who may be confronted with the management of eye, ear, nose, and throat cases during service in the armed forces. It is especially designed to aid in the diagnosis, treatment, and surgical care of conditions which will be most likely encountered by medical men in the field and advanced posts where they must be prepared to care for every conceivable type of case. To many of these men, who will be internists, general practitioners, and general surgeons, this volume will prove of great assistance since it provides concise, authoritative information concerning the more common conditions which may arise.

The ophthalmic section consists of eight brief chapters devoted to Functional Testing, Examination of the Eye, Acute Visual Disturbances, Acute Inflammations of the Eye, Injuries of the Eye, Medical Treatment Including Dressings, Local Anesthesia, and Surgical Procedures.

The section devoted to otolaryngology and rhinology consists of seventeen chapters and, therefore, covers a greater variety of subjects. This is necessitated by the greater number of wounds, fractures, etc. which may involve the region of the face, and the frequency of infections of the nose, throat, ear, and sinuses. Chapters devoted to reeducation of the deafened soldier and reeducation for speech defects are included. While they contain very valuable information and suggestions regarding these conditions, they might be more appropriately assigned to treatises on rehabilitation than to a "brief manual of elementary directions," which is stated to be the aim of the sub-committee.

The manual in no way replaces the text book, but it does provide a valuable ready reference aid and for this purpose cannot be commended too highly. F. A. D.

Advances in Pediatrics, Volume I. Edited by Adolph G. DeSanctis, M. D., New York Postgraduate Medical School and Hospital, Columbia University, New York, with four associate editors, ten contributors. Cloth. Price, $4.50. Pp. 306, illustrated. New York: Interscience Publishers, Inc., 1942.

"Advances in Pediatrics" consists of a collection of monographs by various authors on the following subjects: Toxoplasmosis (fifty-three pages), virus diseases (thirty pages), chemotherapy (thirty-one pages) electroencephalography (twenty-three pages), the role of Vitamin K in hemorrhage in the newborn period (fourteen pages), persistent ductus arteriosus and its surgical treatment (eleven pages), the premature infant (seventeen pages), tuberculosis (thirty pages), endocrinology (forty-five pages). The series of monographs is followed by a final chapter of short discussion of recent publications upon influenzal meningitis, tetanus toxoid, Vitamin C effect on metabolism of tyrosine and phenylalanine in premature infants, oxyuriasis, cystic fibrosis of the pancreas, plasma transfusion, ultraviolet sterilization of air, and rheumatic fever and sulfanilamide.

The subject of each monograph is reviewed by an authority in that field in the light of the current literature, and of his own personal experience. As a result, the reader is presented with a comprehensive and interesting survey of those pediatric advances of the past few years which have aroused the most enthusiastic interest and liveliest discussion.

The book is highly recommended to all those concerned with pediatric practice. For those in such

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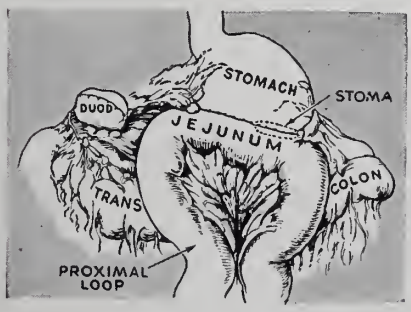

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1. *Fauley, G. B.; Freeman, S.; Ivy, A. C.; Atkinson, A. J.; and Wigodsky, H. S.;* Aluminum Phosphate in the Therapy of Peptic Ulcer, Arch. Int. Med. 67: 563-578 (March) 1941.
2. *Marshall, S. F., and Devine, J. W. Jr.;* Gastrojejunal Ulcer, S. Clin. North America, 743-761 (June) 1941.

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work who find it impossible to keep abreast of current literature it might well be said to be a "must." J. E. G.

Health Education of the Public. By W. W. Bauer, M. D., director of the Bureau of Health Education, American Medical Association, associate editor of *Hygeia*, and Thomas G. Hull, Ph. D., director, Scientific Exhibits, American Medical Association. Cloth. Price, $2.75. Pp. 315, illustrated. Philadelphia: W. B. Saunders Company, 1942.

This is a carefully written volume which is exceedingly well organized and which presents detailed information concerning sources of material, conduct of meetings, use of the radio and motion pictures, organization of exhibits and a multitude of other information on the subject of Health Education.

Valuable suggestions on local health education movements are given, and month to month subjects and topics, either for newspaper or radio use, are given. This text is extensively illustrated and is well indexed. The approach of the health educator to his audience is well presented, and it is pointed out that the physician should acquaint himself with some of the simple and fundamental facts related to public speaking.

Books, pamphlets, plays, magazine articles, stereopticon slides, motion pictures, newspapers, public meetings and other means of spreading the gospel of Public Health are presented and compared in relation to objectives and results. Carefully compiled bibliographies are found at the end of each section. The material is very readable and the physical make-up of this book is pleasant.

In summary, it is an excellent and concise discussion of Health Education and should be a valuable text for the physician as well as the lay reader who is interested in this phase of medicine. L. R. C.

The National Formulary. Prepared by the committee on National Formulary by authority of the American Pharmaceutical Association. Ed. 7, official from November 1, 1942. Cloth. Price, $6. Pp. 690. Easton, Pennsylvania: Mack Printing Company, 1942.

"The National Formulary," seventh edition, covers much the same field as the preceding editions but has been brought up to date. "The National Formulary," like the U. S. P., is recognized as a legal standard but lists preparations generally not included in the U. S. P. Its usefulness, like that of the Pharmacopoeia, would appear to be limited largely to manufacturing concerns and to pharmacists. It contains a vast amount of useful information, useful for those interested in the composition of drugs and drug compounds not listed in the U. S. P. A. L. T.

Stedman's Practical Medical Dictionary. Fifteenth revised edition with Etymologic and Orthographic Rules. By Stanley Thomas Garber, B. S., M. D. Fabrikoid. Price, $7.50 with thumb index (without index $7). Pp. 1,257, with illustrations. Baltimore: William Wood & Company, 1942.

This entire book has been reset for the present edition; there have been many additions, eliminations and corrections. The volume follows closely the previous editions of this work, which have proved so valuable. Special attention has been paid to new terms in the field of the vitamins, biochemistry and chemotherapy, also allergy and hematology. The terminology of bacteria has been revised to conform with the classification by a committee of the Society of American Bacteriologists. New illustrations have been added in considerable numbers. An attempt has been made by the editors to return closely to correct Greek and Latin forms, and what are believed to be the correct forms are the ones used for the attachment of the definitions; for example, the term oophorectomy merely refers the reader to oothecotomy. The word ovariotomy commonly used is also defined under the correct term oothecotomy. Indeed the authors say that even under appendicitis the preferable term scolecoiditis is indicated. In other words, they have defined an ideal and persist in it regardless of the fact that such words as appendicitis, once established, are not likely to be removed from the language in favor of the new term, however correct that may be etymologically. The long eponyms are referred to as main titles and are defined under the proper names.

New and Nonofficial Remedies, 1942, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1942. Cloth. Price, postpaid, $1.50. Pp. 671—XCVII Chicago: American Medical Association, 1942.

Perhaps the most important feature of this new volume of "New and Nonofficial Remedies" is the radical rearrangement it has undergone, which it is believed will make the contents more accessible and therefore more valuable to the physician or other interested readers. Heretofore, the classification of products has been basically that of chemical relationship—the new arrangement is primarily according to therapeutic use, chemical classification being introduced by means of subheadings. In addition, the typographic style has been changed so as to give greater prominence to the products of individual manufacturers. No valuable feature has been sacrificed. The book still fulfills its function of establishing chemical standards for new and nonofficial preparations which the Council has found to be useful or to give adequate promise of usefulness in the treatment or prevention of disease. Its function as a guide to the most recent advances in therapeutics has been greatly enhanced.

Careful examination of the general discussions under the various headings and subheadings shows that the Council has admirably performed its annual task of keeping the text abreast with the progress of medicine. The authoritative and compendious section of the sulfonamide derivatives is an outstanding example. So also is the chapter, Vitamins and Vitamin Preparations for Prophylactic and Therapeutic Use. Equally important though less extensive revisions have been made in such sections as, Aluminum Compounds, Dextrose, Gonadotropic

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Others worthy of mention are: Cyclopropane, another general anesthetic, now included in the U. S. P.; Amylcaine Hydrochloride, another proprietary local anesthetic and Pernoston Sodium, the sodium salt of the previously accepted proprietary barbital derivative, Pernoston.

The indices of the new volume of "New and Nonofficial Remedies" are of the same order and plan as in previous editions. A general index lists accepted articles, including those not described. This is followed by an index to distributors in which appear all the Council accepted articles listed under their respective manufacturers. Finally, a bibliographic index is added for listing proprietary and unofficial articles not included in "New and Nonofficial Remedies." This includes references to the Council publications concerning each such article as has appeared in *The Journal of the American Medical Association*, Reports of the Council on Pharmacy and Chemistry, Propaganda for Reform, Vol. 1 and 2, or Reports of the American Medical Association Chemical Laboratory.

Clinics. A bimonthly publication. Edited by George Morris Piersol, M. D., professor of medicine, Graduate School of Medicine, University of Pennsylvania, Philadelphia; with sixteen collaborators and twenty-nine contributors. Paper. Price, $12 per year subscription. Pp. 264. Philadelphia: J. B. Lippincott, June, 1942.

"Clinics" is a new publication. It succeeds the "New International Clinics." Its purpose is to report timely, practical, useful articles for the general practitioner. It aims at greater adequacy and flexibility than its predecessor. It is the intention of the editors and publishers to do a job of medical reporting by bringing to the attention of the practitioner good work wherever and whenever found. It is neither a digest nor an abstraction of current medical literature; its articles are all especially prepared for this one publication.

From a survey of the contents of this first issue it would seem that this publication should fill a real need. The "Symposium on Burns and Shock," consisting of six related articles, reads like the manuscript of a text as yet unpublished. It brings up-to-date the current opinion on these two related subjects before their appearance in a standard text book in such a way that the reader is saved the trouble of searching through voluminous literature for the same information. The authors are all well known clinicians whose personal experiences add much to the value of the Symposium.

The second section concerns itself with original contributions on Epidemic Influenza, Headache, and Evaluation of Cardiac Conditions. A third section concerns itself with the presentation of clinics on a variety of subjects, chiefly in the field of internal medicine. These include such subjects as Generalized Adenopathy, the Diagnosis of Hematuria, Prepubertal Vulvovaginitis, The Management of Rupture of the Uterus, Auricular Flutter, Vitamin D Deficiency, Tuberculous Pericarditis, and the Diagnosis of Pulmonary Disease. A final section, Review of Recent Progress, confines itself to a single article on the "Responses of Peripheral Blood Vessels in Man to Various Drugs."

In subsequent issues, Symposia will appear on Nutrition, Hemorrhage, Transfusions and Blood Substitutes, Endocrinology, Neuro-surgery, Industrial Diseases, Hygiene, Arthritis and Rheumatism, Pediatrics, Obstetrics, Gynecology, and Social Psychiatry. As supplement to the physician's current medical journals and standard text books, this publication should fulfil a need in helping one keep up on medical progress with a saving of time. K. L. P.

Internal Medicine in Old Age. By Albert Mueller-Deham, M. D., associate visiting physician, Welfare Hospital for Chronic Disease (Second Division), Department of Hospitals, New York City; formerly clinical professor of internal medicine, University of Vienna Medical School, and chief of Medical Division, Municipal Hospital for Chronic Disease, Vienna, and S. Milton Rabson, M. D., assistant professor of pathology, New York Postgraduate Medical School, Columbia University (on leave); Lieutenant Commander, United States Naval Reserve. Cloth. Price $5. Pp. 396. Baltimore: The Williams & Wilkins Company, 1942.

With the increasing longevity of the population generally, geriatric problems will increase and demand a constantly increasing attention of the medical profession. Therefore, this text on "Internal

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Medicine in Old Age" and like texts should be making their appearance. It would seem that such a publication would concern itself with the terminal manifestations of diseases as they appear in the aged. At least that was what the thought of the reviewer was before undertaking review of this book. It must be appreciated, however, that it is difficult to draw lines sharply between that material presented in a general text book of medicine and a text on geriatrics. There must be some overlapping. The aim of a text on geriatrics, however, primarily should be a consideration of the problems not only of disease, especially chronic disease in its terminal manifestations, but of a modification of disease by age.

The reviewer has been disappointed in finding included in this book much material which he feels is unrelated to old age. It is felt that the inclusion of such material increases unnecessarily the price of the book and hides somewhat the availability of information on geriatric problems. To include such subjects as Weil's disease and cardiospasm, to list just two examples, seems entirely superfluous. These diseases, and many more which are treated very superficially, would strengthen the book by their omission. On the other hand, there are commendable chapters on the anatomy, physiology, and hygiene of old age. Especially to be commended is the presentation on the treatment of cardiac disease in the aged. Many misconceptions as to the incidence of various diseases in the aged are corrected. The existence of tuberculosis in the aged is cited as a notable example.

Despite what might appear to be unfavorable criticism, this book is recommended. It will be noted that its defections in the opinion of the reviewer are those of inclusion of too much rather than too little material, probably an asset rather than a liability. K. L. P.

Mental Illness: A Guide for the Family. By Edith M. Stern, with the collaboration of Samuel W. Hamilton, M. D., mental hospital advisor, U. S. Public Health Service. Cloth. Price, $1. Pp. 134. New York: The Commonwealth Fund, 1942.

This is, considering the difficult subject matter, a surprisingly well written and up-to-date little volume. It is most complete in its instructions to the family of the mentally ill patient. Furthermore, it is carefully and appropriately reassuring regarding the nature, treatment and prognosis of psychiatric disorders. The author discusses completely the manner in which and the reasons for which one should hospitalize a patient. Although the context is generally adjusted to the language level of the layman, one notices occasional phrases which are of a somewhat too technical nature. It is perhaps unfortunate that the author does not strengthen her arguments with a short discourse to the relatives on the fact that they themselves often play a large etiologic rôle in many psychiatric patient's conditions.

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The book is completed by a useful appendix, by states, which will aid the family in institutionalizing patients, and by a glossary of psychiatric terms.

This work, if somewhat sentimental at times, should prove most helpful to many physicians, and especially those in general practice. J. S. J.

The Pharmacopoeia of the United States of America. Prepared by the Committee of Revision of the Pharmacopoeia of the United States, by authority of the United States Pharmacopoeial Convention. Revision XII., official from November 1, 1942. Cloth. Price, $7.50. Pp. 880, with U. S. P. supplements to be issued. Easton, Pennsylvania: Mack Printing Company, 1942.

The twelfth revision of the U. S. P. has appeared earlier than usual, which marks a radical change from custom in that revisions are contemplated every five years instead of ten as heretofore.

The U. S. P. XII contains a total of 160 new admissions, including many new official forms such as solutions and tablets. Deletions are eighty-six in number. Thus the urge is to increase rather than to decrease the number of official preparations. Such substances as trichlorethylene and vinethene are clearly of doubtful merit as drugs deserving a place in the U. S. P. Other examples could be cited similarly.

The standard of digitalis and method of bioassay have been changed. The U. S. P. XII digitalis is weaker than that of the U. S. P. XI and approximates that of the U. S. P. X. Assay is made by the use of the "cat method" exclusively. As an aside, one of the advocates of the "cat method" of assay states that no preparation of digitalis deteriorates on standing when such preparations are assayed by this method ("cat method"). It will be interesting to see how other clinicians take to this heterodox view of the stability of digitalis preparations. A. L. T.

Military Surgical Manuals. Volume III. Abdominal and Genito-Urinary Injuries. Prepared under the auspices of the committee on surgery of the division of medical sciences of the National Research Council. Cloth. Price, $3. Pp. 243, with seventy-nine illustrations. Philadelphia: W. B. Saunders Company, 1942.

"Abdominal and Genito-Urinary Injuries" was prepared under the auspices of the Committee on Surgery of the Division of Medical Sciences of the National Research Council with a foreword by the Surgeon General of the Army and the Surgeon General of the Navy. Because the later results in war surgery depend on the early care, which must of necessity cover a wide field, by medical officers who for the most part cannot be highly specialized in each field, the general fundamental principles are discussed briefly and to the point. Many illustrations are used. It is well written and organized and should serve its purpose very well. This book could well deserve wide distribution among the general medical profession at this time. E. R. S.

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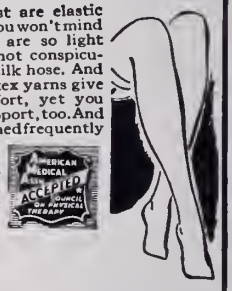
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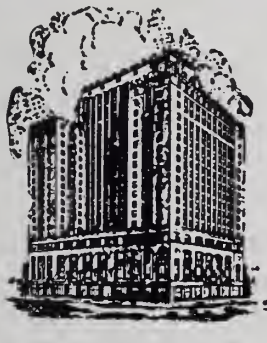

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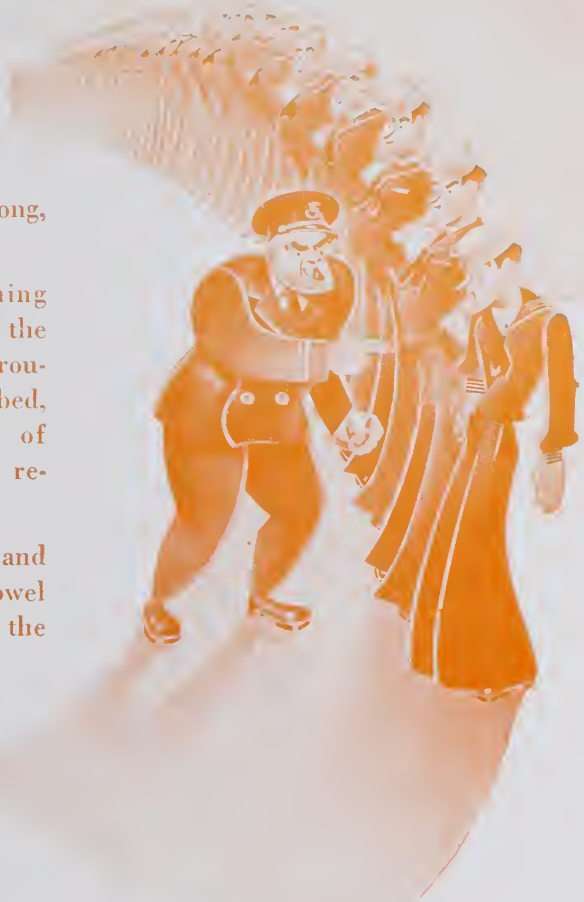

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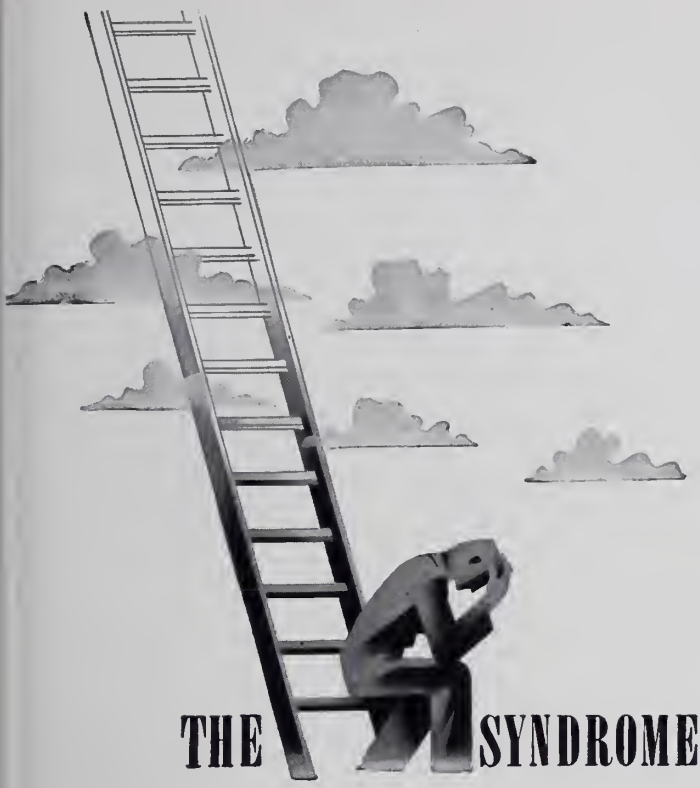

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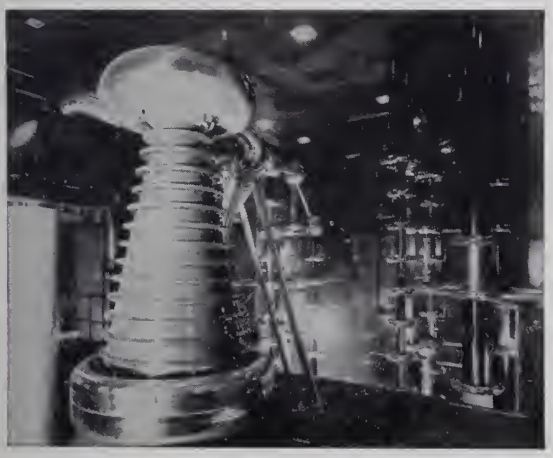

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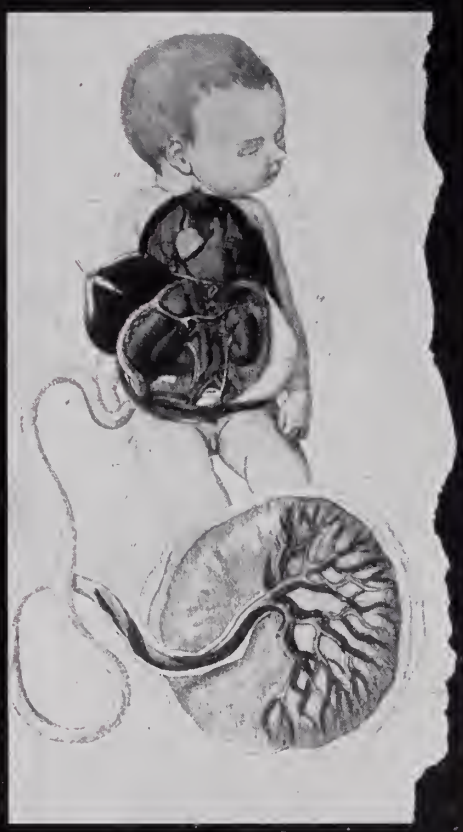

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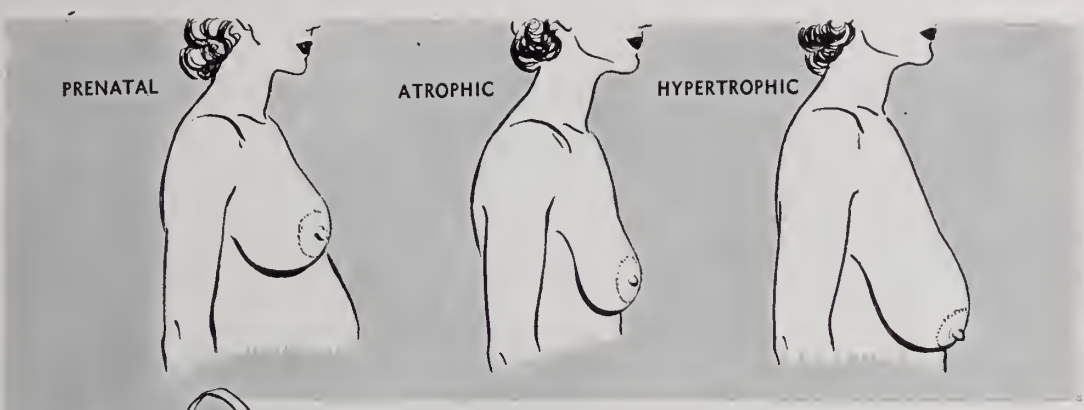

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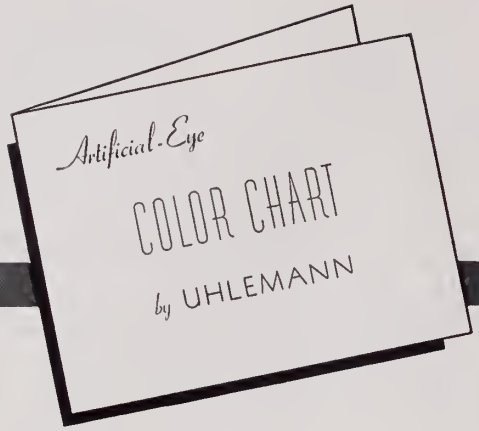

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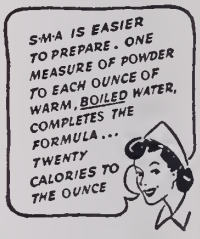

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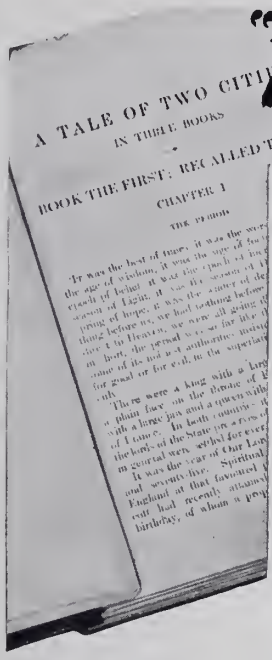

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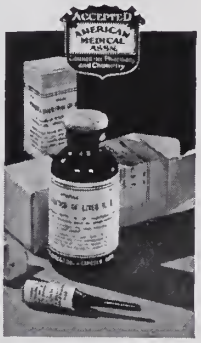

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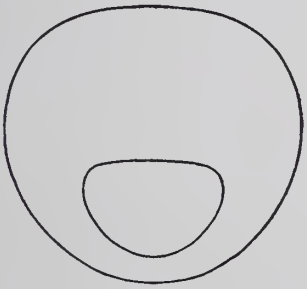

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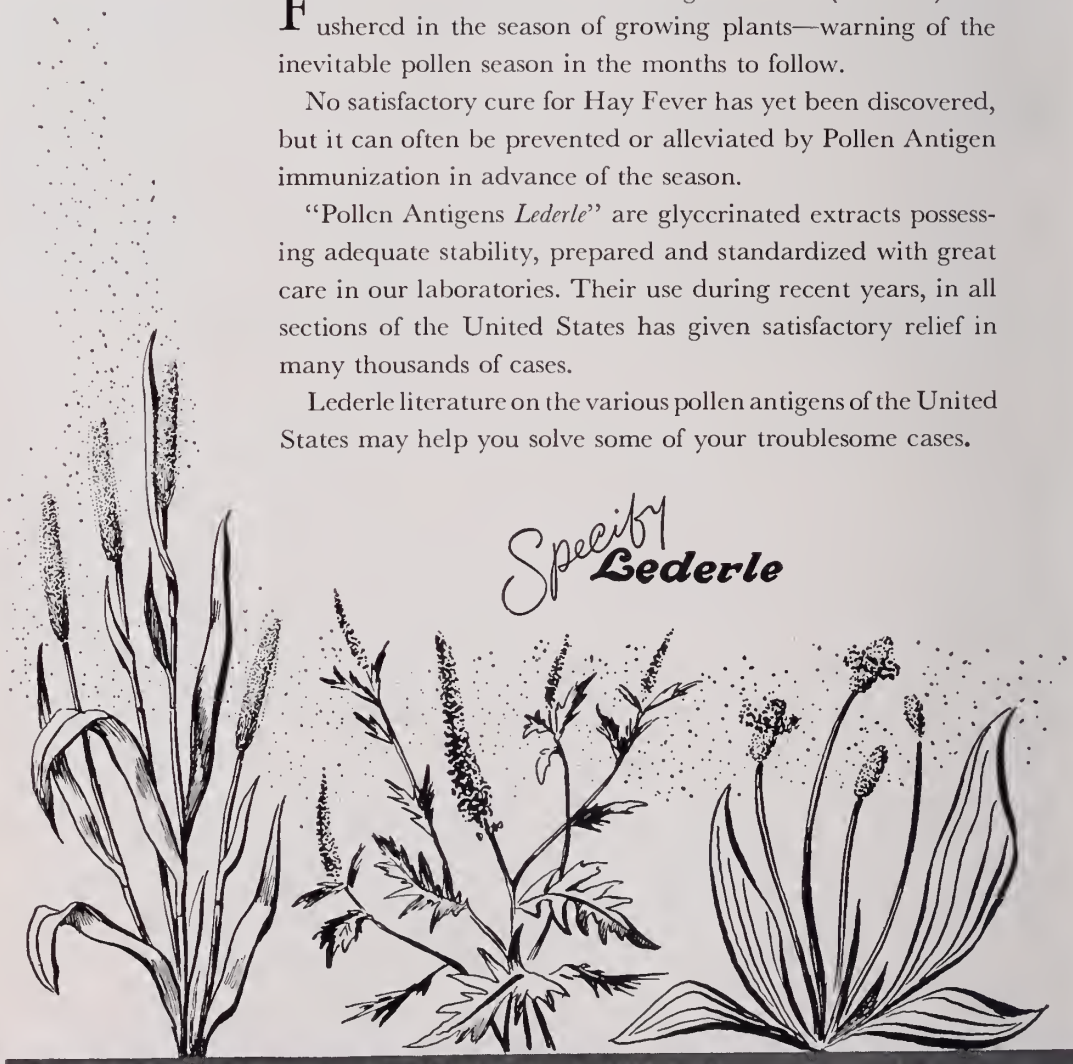

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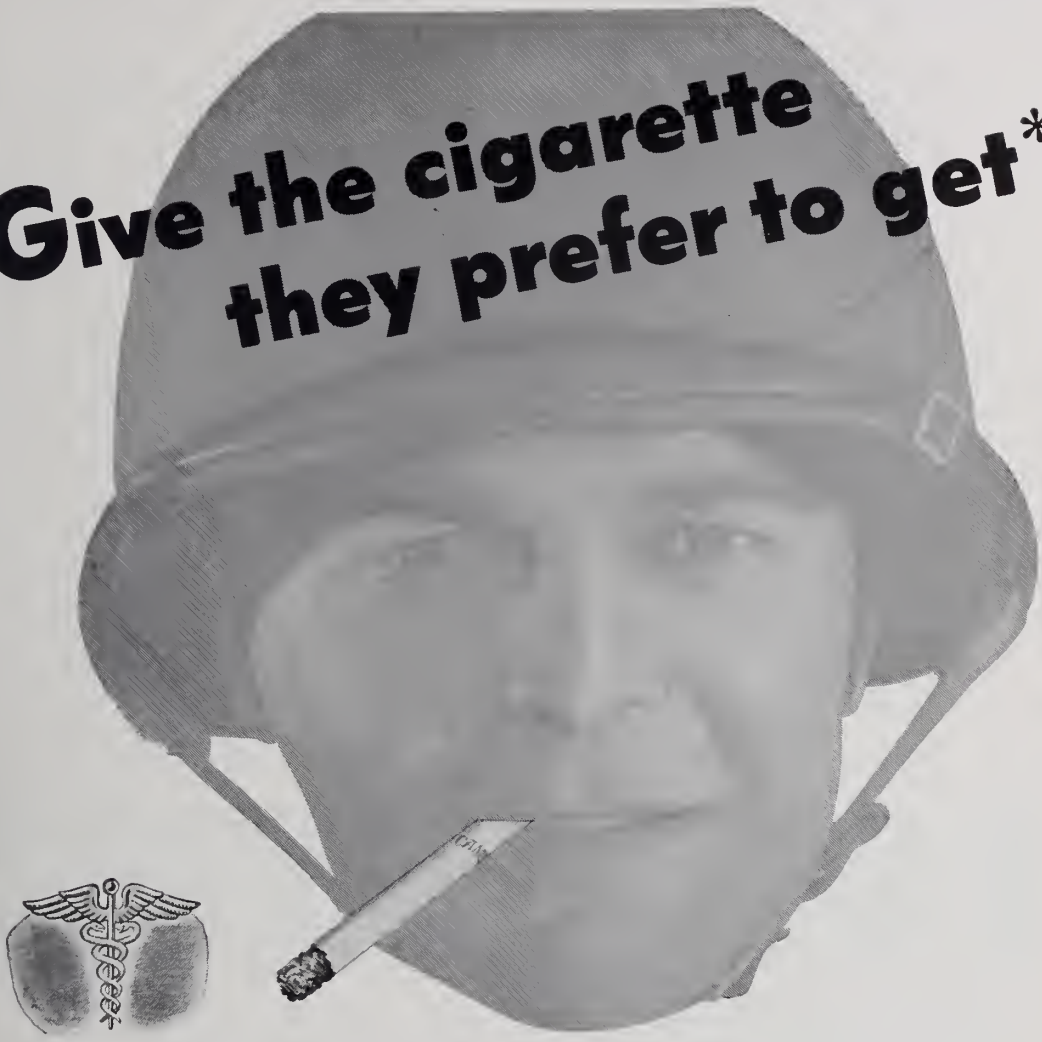

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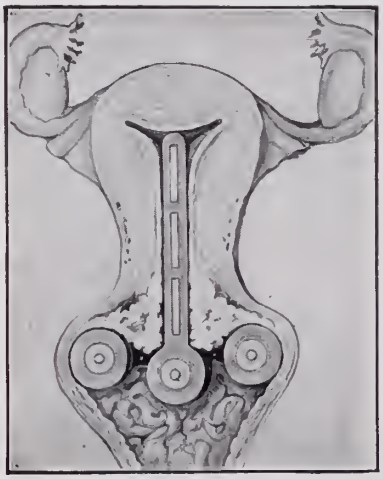

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Dysphagia: A Review of the Clinical, Roentgen Ray, and Esophagoscopic Aspects of 150 Cases

By GERHARD D. STRAUS, M. D.*

Milwaukee

DYSPHAGIA is the symptom that is of first importance in the diagnosis of esophageal disease, since the conveyance of food and oral secretions to the stomach is, as far as we know, the sole function of the esophagus. Most disease processes in this organ either cause obstruction in themselves, as for example in carcinoma or stricture, or cause spasms which in turn cause obstruction symptoms, as in an abrasion or a small foreign body. One exception of importance to the above generalization is that of esophageal varices; here the only symptom may be hemorrhage.

It is important for the clinician to recognize dysphagia as a symptom which entitles the patient to painstaking investigation. This should include a thorough physical examination, an examination of the larynx and pyriform sinuses using the laryngeal mirror, fluoroscopic and roentgen ray studies of the esophagus with the use of barium sulfate, and an esophagoscopy. Blind bouginage of the esophagus should never under any circumstances be done, for it is possible to perforate the esophagus in cases of diverticuli, carcinoma, or benign stricture, with very little pressure. Such a perforation will usually lead to mediastinitis.

Occasionally one will see cases where roentgen ray studies of the esophagus are negative, yet esophagoscopy will reveal pathology which might have been missed.

Too often we find people who complain of difficulty in swallowing classified as psychoneurosis, globus hystericus, or functional dysphagia. Many such people return later with advanced esophageal pathology.

Pathology in 150 Patients

During the last two years I have examined 150 patients with the esophagoscope. Well over half of these exhibited some form of esophageal pathology. Forty cases were proved by biopsies obtained through the esophagoscope to have carcinoma. Most of these people were in the late middle or old age groups. All complained of dysphagia ranging in duration from four weeks to one year. The average duration was four months. Very few presented themselves before they were unable to swallow anything but liquids. Unfortunately, many were treated with antispasmodics and sedatives for months before any scientific diagnostic work was done.

Today, with improved surgery[1] and radiation therapy, there is some hope for people suffering from this disease providing that an early diagnosis is made. The average patient who presents himself four months after the onset of symptoms is usually far beyond the range of any such help.

In the mirror examination of patients with esophageal carcinoma or, for that matter, any obstructive esophageal disease, one will very often see an accumulation of mucus and saliva in the pyriform sinuses. This is a very suggestive sign. Roentgenography of the esophagus using barium sulfate will reveal a ragged constricting lesion which may be located anywhere in the esophagus, usually, however, in the lower or middle third. Above these lesions there is usually an area

* At present Lieutenant, Medical Corps, United States Army.

of moderate dilatation. This is an important feature in the roentgen ray diagnosis since malignant lesions never show the extreme dilatations that benign lesions show. Three cases, however, showed no abnormalities on roentgen ray examination. But since it is a good policy to esophagoscope all patients with persistent dysphagia, these patients were also examined and positive biopsies for cancer were obtained, two from the esophagus and one from the upper part of the stomach.

As viewed through the esophagoscope, these lesions have a polypoid or papillary appearance and bleed easily when they are touched with an endoscope.

Thirty-seven cases showed various grades of squamous cell carcinoma, and three were adenocarcinomas.

Foreign Bodies in the Esophagus

The dysphagia caused by foreign bodies in the esophagus is usually acute, though it may be of several days' duration, and varies from the ability to swallow only liquids to the inability to swallow anything. There were 23 cases in this category. Most of the foreign bodies were lodged in the upper third of the esophagus at the level of the superior constriction, that is at the level of the cricopharyngeus muscle. Lateral roentgenograms of the neck usually revealed the presence of a radiopaque foreign body but nonopaque objects, and frequently, objects at lower levels required the use of a barium sulfate mixture (fig. 1) or a barium filled capsule to show the presence of the obstructing substance. Seven additional cases were esophagoscoped for suspected foreign bodies, but only abrasions of the esophagus could be seen, which had been caused by foreign bodies that had passed on downward.

In 1 case, an open safety pin was lodged point upward in a 2 year old child. It was found impossible to extract the pin without the risk of damaging the esophagus, so it was pushed into the stomach. The pin was recovered in the stool about four days later, the child having had no discomfort. In three other cases of safety pins, the pins were successfully removed through the mouth. It is important that foreign bodies be removed

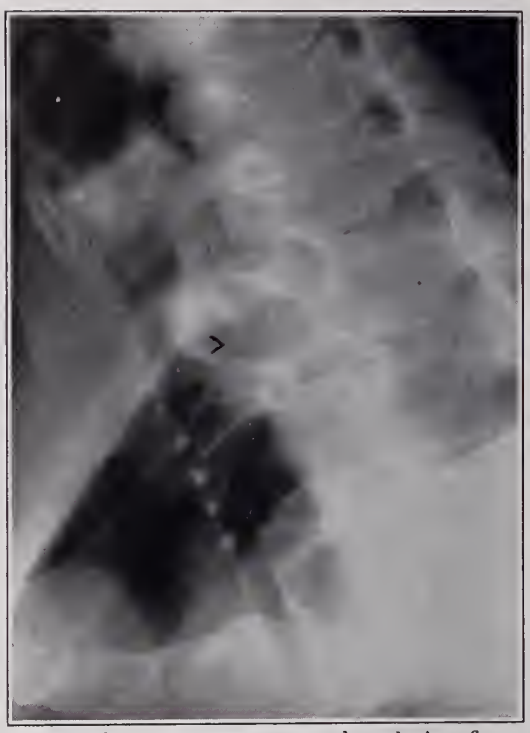

Fig. 1. Spot roentgenogram taken during fluoroscopy. The arrow designates the cap of barium above a nonopaque body (meat).

Fig. 2. A case of cardiospasm. Note the rather smooth contour of the constriction and the generalized dilatation of the esophagus.

without perforating the esophagus since mediastinitis is the common result of such perforations.

There were 2 cases of cardiospasm or preventriculosis. (fig. 2) In such cases, the dilatation of the esophagus may become rather great.

One patient had a marked hyperthyroidism which apparently caused esophageal spasm.

One case with a typical Plummer–Vinson's syndrome (dysphagia associated with hypochromic anemia) was found to be negative on esophagoscopic examination, although webs in the upper third of the esophagus have been reported in such cases.[2]

There were 3 cases of esophageal diverticulum. One of these was a typical pulsion diverticulum which pushed backward through the anatomic weak spot in the esophageal, or more properly, the hypopharyngeal wall. (fig. 3) In these cases, the pouch may become so large that the remaining esophagus is reduced to a small, fibrotic, fistulalike affair through which no food passes. In the esophagoscopic examination of the above case, the scope passed directly into the pouch, but it was impossible to find the true lumen of the esophagus.

The other 2 cases were traction diverticuli, which are usually much smaller. Cancer was suspected in the orifice of one of them, but this was ruled out by the esophagoscopic examination. (fig. 4)

Fig. 3. Pulsion diverticulum. None of the barium passes into the true esophagus.

Fig. 4. Traction diverticulum is designated by the arrow.

Strictures Caused by Chemical Burns

There were 3 cases of benign stricture caused by chemical burns. Two were lye burns and one was due to ammonia. These patients were treated by performing gastronesteostomies and then having the patient swallow a string. The string is pulled through the gastronesteostomy, and then the stricture is dilated by retrograde bouginage using the Tucker bougies. It is wise to esophagoscope these patients in the later stages of dilatation in order to study the condition of the esophageal wall.

There were 2 cases of external tumors compressing the esophagus and causing dysphagia. One was a thyroid gland tumor and the other a mediastinal tumor. The roent-

genograms in cases of this type show a smooth contour to the constriction. One patient had an esophagitis causing a marked dysphagia which cleared up after several badly infected teeth were extracted.

One case of blastomycosis of the esophagus was seen and proved by biopsy. The roentgenogram showed a ragged lesion of the esophagus which suggested carcinoma, but the dilatation was greater than is usually seen in malignancy. (fig. 5) This case has been reported in detail elsewhere.[3]

In considering the esophagoscopic technic, the Jackson distally lighted esophagoscopes are preferable in most cases. However, for some cases, particularly for foreign bodies caught at the cricopharyngeus, the Haslinger proximally lighted scopes are often very efficient. The esophagoscopies are done under local anesthesia; 2 per cent pontocaine or cocaine sprayed into the pharynx provides adequate anesthesia. It is important that adequate preoperative medication be given. For the average adult, I use nembutal 1½ grains, morphine sulfate ¼ grain, and scopolamine 1/100 grain, given one and a half hours preoperatively.

Summary

A review of the pathology seen in 150 patients who were esophagoscoped in the last two years is presented. Dysphagia is a symptom which may mean serious trouble, and thorough studies including roentgenography and esophagoscopy should be made in all people who complain of persistent difficulty in swallowing.

Fig. 5. Blastomycosis of the esophagus. Note the rather marked dilatation above the lesion.

BIBLIOGRAPHY

1. Phemister, D. B.: Resection for Carcinoma of Esophagus, Surg., Gynec. & Obst. 74:266 (Feb.) 1942.
2. Cordray, D. P.: The Plummer–Vinson Syndrome, Ann. Otol., Rhin. & Laryng. 49:160 (March) 1940.
3. Straus, G. D.: Blastomycosis of the Esophagus, Arch. Otolaryng. 32:1082 (Dec.) 1940.

Pulmonary Nodular Infiltrations in Influenza Resembling an Early Tuberculosis

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WHEN there is an increase in the incidence of sporadic cases of influenza, then there is an increase also in the group characterized by a nodular infiltration of the lungs that must be differentiated from an early tuberculous infiltration.[1] This fact has been known for many years, but recently the detection of the nodular type has been made easier by roentgen ray examination. With more frequent roentgenography of the lungs, as a routine procedure, clinicians have been impressed with the fact that after a short period of fever, etc., lung pathology is often discovered in influenza cases which had no correlative, significant, disabling symptoms except persistent cough and mucopurulent sputum. If a patient is critically ill, the clinician is practically forced to

rule out a "probable" pulmonary tuberculosis. This is particularly true in regard to hospitalized cases, with whom the facility for repeated roentgen ray examinations is taken advantage of more readily, and especially when they are checked by a series of roentgenograms which show initially a nodular or pseudomiliary type of influenza and later disclose small, localized, confluent areas of spreading peribronchial pathology.

These roentgenologic findings have added some confusion to the problem of differential diagnosis. In order of frequency, nodular or miliary tuberculosis, pneumoconiosis with secondary infection, and nodular carcinoma must be differentiated. When he is faced with this problem, the clinician's reaction of uncertainty is reflected in prolonging the disability of his patient until repeated roentgen ray examinations finally disclose clear lung fields.

Retrogressive Pathology in Respiratory Influenza

Therefore, a brief review of the retrogressive pathology that often occurs during the respiratory type of influenza deserves special mention. Peribronchial or pseudolobular pneumonic consolidation is a frequent complication of the respiratory (tracheobronchial) type of influenza. Miller[1] states that "Sometimes, though rarely, this approaches a true lobar type of consolidation." In their monograph, Winternitz and his fellow workers[2] emphasized "that certain progressive anatomic changes occur even when the disease runs a much less severe clinical course . . . It appears also that variations in the extent, and perhaps in the maturation of the anatomic involvement may be represented in different proportions for different localities."

Often a tracheobronchitis is present with no symptoms that can be referred to the lung parenchyma. Clinical improvement may occur with or without pulmonary involvement. On the other hand, pulmonary involvement very often occurs with symptoms pathognomonic of parenchymal involvement.

Initial Parenchymal Involvement

The initial parenchymal involvement in a pure influenza is made up of a diffuse, aplastic, alveolar exudate, with disruption and necrosis of the epithelial layer lining the bronchioles and air sacs, and an inflammatory invasion of the adjacent interstitial tissues. These lesions are scattered, and are usually followed by resolution, or rarely by organization.

Shadows Suggesting Tuberculous Condition

Early in the attack or later during the stage of organization or delayed resolution when clinical symptoms are insignificant or absent, a roentgenogram taken then will often show shadows *suggestive* of a nodular tuberculous condition. These shadows, or abnormal variations in the density of the lung parenchyma and air passages, usually represent a slowly organizing pneumonic process when they are examined under the microscope. They are found to represent one of several conditions: (1) small areas of consolidation, (2) temporary fine fibroblastic and fibrillar connective tissue transformation of the inflammatory exudate, (3) temporary occlusion of the air spaces by a fine exudate filled with hyperplastic epithelium, or (4) conversion of the inflammatory field into persistent scar tissue, sufficient to distort the normal architecture of the lung.

The presence of an exudate stimulates invasion by capillaries and connective tissue cells which grow in from the terminal bronchiole, finally obliterating the air spaces. This usually occurs in patches.[3] In influenza, a characteristic hyalinization of the epithelium of the air passages with necrosis of the air sac walls at times prevents a proper redisposition of the newborn lining epithelium of the bronchioles and the respiratory epithelium of the alveoli, so that an extensive epithelial proliferation continues into dilated air spaces or surrounds the residual tiny fragments of exudate which lie in the airways. In the last instance, the airways and air sacs are completely occluded or are invaded by tonguelike projections.

Even on gross examination of these lungs, with no clinical history available to provide clues, the pathologist might mistake the tissue for a nodular tuberculosis,[4-6] or rarely nodular malignancy.

Why Healing Process is Delayed

Although the pathologic process in the great majority of these lungs clears up eventually, the question arises as to why healing is delayed in some cases. The suggestion has been made that the alveolar and bronchial exudate observed in influenzal pneumonia (usually pseudolobular) does not dissolve easily because the exudate is poorly supplied with polymorphonuclear leukocytes. It is also known that the blood leukocyte count shows a decrease or no significant deviation from the average normal. Whether this is due to the fact that the bone marrow is influenced unfavorably by an unknown virus or toxic product, and may therefore indirectly have some bearing on the functional activity of the polymorphonuclear leukocytes at the site of exudation, is at present purely speculative. In any event, it has been claimed that the scarcity of the leukocyte results either in a quantitative decrease of their proteolytic enzymes or in an inhibition of the proteolytic action of the leukocytic enzymes.[7, 8]

Summary

1. The detection of an unsuspected delayed resolution of a nodular pneumonic process in respiratory influenza is a fairly common finding now with increased roentgen ray facilities.

2. The delay in the evolution of repair of the pathologic process requires reemphasis, because there is a tendency to confuse it with an early or postinfluenzal tuberculous invasion.

3. The process usually clears up within a month from the day of the first roentgen ray examination.

4. An understanding of the basic pathology of influenza in the lung will eliminate somewhat the confusion in differential diagnosis and prognosis of the nodular type of influenza.

BIBLIOGRAPHY

1. Miller, James Alexander: Pulmonary Tuberculosis in Adults, Nelson's Loose-leaf Living Medicine, New York, Thomas Nelson & Sons, 1938, vol. 1, p. 334W.
2. Winternitz, M. C.; Wason, I. M., and McNamara, F. P.: The Pathology of Influenza, New Haven, Yale University Press, 1920.
3. Bell, E. T.: A Textbook of Pathology, Philadelphia, Lea & Febinger, 1938, p. 527.
4. Boyd, Wm.: The Pathology of Internal Diseases, Philadelphia, Lea & Febinger, 1932, p. 174.
5. MacCallum, W. G.: Textbook of Pathology, ed. 3, Philadelphia, W. B. Saunders Company, 1935, p. 596.
6. Freund, H. A.: Influenza, in Tice: Practice of Medicine, Hagerstown, Md., W. F. Prior Company, 1941, vol. 5, pp. 296 and 306.
7. Winternitz, M. C.; Wason, I. M., and McNamara, F. P.: The Pathology of Influenza, New Haven, Yale University Press, 1920, p. 47.
8. Boyd, Wm.: The Pathology of Internal Diseases, Philadelphia, Lea & Febinger, 1932, p. 159.

Recent Advances in the Use of Human Serum and Plasma*

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WORLD War I provided a great impetus to the study of the problem of shock. The result of that impetus was a succession of advances in the knowledge of the etiology, pathologic physiology and treatment of shock. Twenty-five years later at the onset of World War II, we have a scientific background which enables us to deal with the problem more intelligently and effectively. As the war progresses, we are provided with a means of applying this knowledge and observing its results. It is the purpose of this paper to discuss some of the advances which have been made in the use of blood substitutes in the treatment of shock.

While the pathology of shock is still controversial, it is now generally agreed that a primary disturbance is the decrease in circulating blood volume with resulting hemoconcentration and reduced cardiac output.[1, 2] Fluid escapes from the blood stream into the

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tissues carrying plasma protein with it. Recognition of these facts led to the use of whole blood in the treatment of shock. The delay attendant on typing, cross matching, and serologic tests renders whole blood unsuitable for use in the emergency treatment of shock. Consequently, blood substitutes were sought which could be stored and given immediately.

Acacia was used for a time but is no longer deemed advisable because of the immediate and delayed reactions produced by it. At the present time, human serum and plasma are considered adequate blood substitutes for use in the treatment of shock and other conditions where hypoproteinemia exists.

Serum is the clear, straw-colored fluid resulting from clotted blood. It contains no fibrinogen and remains clear indefinitely if kept at 4C. Plasma is obtained by centrifuging whole blood to which an anticoagulant has been added. It is at first a clear fluid containing fibrinogen, but as it ages, a flocculent fibrin forms. When one is working with stored blood, plasma may be withdrawn between the fifth and fifteenth day, when the whole blood has become less desirable for use. The red blood cells can also be salvaged for use by resuspending them in a glucose mixture.[3]

Serum Versus Plasma

Considerable controversy has arisen as to whether serum or plasma is better to use. The yield of plasma and serum from whole blood is about the same—50 per cent. Where a blood bank is in operation, it would appear more feasible to use plasma. In the absence of a blood bank, however, serum is a more desirable product since no flocculation occurs. Filtration at the time of administration is unnecessary. There is apparently no known therapeutic difference between serum and plasma.[4, 5]

Dried serum and plasma are being prepared by many workers. One purpose of these products is to supply military forces with a blood substitute for the treatment of war injuries. These dried products provide a substance which is stable without refrigeration, small in bulk, and easily transported. They are reconstituted with water to the desired concentration before using. Spray distillation in vacuo produces a satisfactory concentrated product for clinical use.[3] Cellophane bags have been used to produce dried serum as well as the liquid concentrated form.[6, 7] Neither of these methods has been developed for production on a large scale. Patents cover many of the machines which are capable of producing great amounts of dried serum. (Lyophile, 8; Cryochem, 9; Desivac, 10; and Adtevac, 11)

Reactions are uncommon following the use of human serum or plasma if they are properly prepared and carefully administered.[4, 12, 13] The pooling of a large number of bulk sera of varying blood groups yields a low agglutinin titer serum. The agglutinogens in the patient's serum absorb the infused agglutinins and inhibit their action on the patient's red blood cells. In our experience, mild urticarial reactions and transient slight temperature elevations have occurred in less than one-half of 1 per cent in over 8,000 injections of convalescent serum during the last six years. The "fibrin veil" occurring in stored plasma must be filtered out before using the fluid intravenously, for one death has been reported from unfiltered plasma.[14]

Serum Satisfactory in Civilian Community

Normal liquid serum is a satisfactory product for general use in a civilian community such as ours where refrigeration and rapid transportation are easily accomplished. The preparation of the substance requires meticulous attention to details. The established principles and requirements of the National Institute of Health should be carefully observed. Two hundred and fifty cc. of blood are withdrawn from a normal, fasting, adult donor into a centrifuge bottle, which is then placed in an ice box for twenty-four hours. After this time, the clot is broken, the blood is centrifuged, and the clear, supernatant serum is withdrawn. A portion of the serum is taken for sterility tests and serologic examinations for syphilis. If these tests are negative, thirty of the bulks are pooled and a preservative is added (1:10,000 merthiolate). The serum is then

passed through a Berkefeld filter and is placed in the final container, an ordinary commercial vacuum bottle, in quantities of 250 cc. and 500 cc. Final sterility tests are performed, and if satisfactory after one week's time, the serum is ready for use.

Normal dog serum has been shown to be effective in combating experimental shock, plasmapheresis hypoproteinemia, shock from repeated hemorrhage and protein starvation in dogs.[15, 16, 17, 18, 19, 20, 21]

Shock Without Hemorrhage

The field for the greatest use of plasma and serum is in shock without hemorrhage. In this condition, there is no loss of blood, but there is a marked dilation of the capillaries and a loss of fluid from the blood vessels into the tissues. This loss of fluid occurs both in the region of traumatic injury and also into other tissues of the body as the result of increased capillary permeability. The hematocrit,[22] the hemoglobin,[23] and the red blood cell count,[24] have been used clinically to determine the degree of hemoconcentration. With these changes occur a diminished blood volume, slowed and inadequate circulation, and anoxemia of the tissues. The intravenous injection of serum or plasma replaces the fluid loss and increases the blood volume within the vessels. This increases the circulation and improves the anoxemia. To give whole blood would add to the hemoconcentration already present in these cases of shock. The British[23] favor the infusion of normal isotonic serum or plasma as being superior to the more concentrated forms.[12] The average amount per injection varies between 250 cc. and 500 cc. Repeated doses depend on the clinical condition of the patient and the hematocrit reading.

Clinical estimation of shock is necessary in emergencies. The following represents a case of shock occurring during the course of a surgical procedure:

A young woman of 19 who was being operated on for an appendical abscess went into shock. Her pulse increased to 158, her respiration became shallow, and her systolic pressure dropped below 80. Five hundred cc. of normal liquid serum were given intravenously. Her pulse decreased to 144, and her blood pressure rose to 102/72 before the injection was complete. In twenty minutes the major signs of shock had disappeared. Several hours later the pulse was well established at 120 and the blood pressure at 128/90.

Immediate treatment is of the utmost importance in shock resulting from massive hemorrhage. The use of a prepared donor reduces time loss. If stored blood is available, it reduces this time loss still further. Serum or plasma can be given promptly even without the delay of cross matching. Thus, the blood volume and blood pressure may be sustained until whole blood can be obtained and given.[13] However, repeated injections of serum or plasma should be used with caution if the hemoglobin is less than 50 per cent, because they may produce forced and excessive dilutions of the blood.[25]

The following is an example of the use of serum in a case of shock following hemorrhage.

Severe shock appeared during the examination of a woman having a suspected ectopic pregnancy. This occurred in the doctor's downtown office. Serum was secured, given, and the patient brought out of shock. An hour later a donor was found and a transfusion given. The patient was then operated upon and found to have a ruptured tubal pregnancy. Shock did not recur.

Burns

In extensive burns, there is a loss of fluid and proteins through damaged capillaries into the body tissues as well as a loss of fluid and protein from the burned surface. Crystalloid solutions (saline, glucose) do not have colloid properties and, when injected, soon escape from the capillary bed and thus fail to relieve the hemoconcentration. The administration of adequate amounts of serum or plasma overcomes the loss of fluid, the decrease in proteins,[26, 27] and corrects the distorted serum to red blood cell ratio.[28] It has been suggested that for adults 100 cc. of serum or plasma be given for every point the hematocrit is above 45. When the plasma proteins are below 6.0 Gm./100 cc., an additional 25 per cent of the calculated amount should be added for every gram the protein level is below 6.0 Gm.[22]

The following case of severe burn in a child shows the diluting value of serum in the hemoconcentration occurring in burns.

The child had received 200 cc. of whole blood. The red blood cell count was 6,300,000, and the hemoglobin was 15.5 Gm. After 250 cc. of serum, the red blood cell count dropped to 4,000,000 and the hemoglobin to 12.5 Gm.

Conditions Involving Hypoproteinemia

Numerous reports are appearing on the use of concentrated human serum and plasma in conditions other than shock and burns. These deal with conditions in which there is a hypoproteinemia. Early cases of nephrosis have been thought to have been aided by the injection of rather large amounts of concentrated serum. Diuresis frequently occurs with elimination of the edema fluid.[29] It is possible that the injection of natural proteins contained in the serum would be of value in some cases of acute or subacute liver disorders. For the chronic disorders of the liver, they may be of palliative value. Concentrated serum has also been used for the reduction of increased intracranial pressure. Delayed wound healing after extensive intestinal operations has been thought to be due to diminished assimilation and production of protein with resulting local edema at site of anastomosis. Serum corrects the edema by elevating the blood protein.[30, 31]

The following is a case report of a 28 year old male on whom a colonic resection had been done for a familial multiple polyposis of the colon:

On the fifth postoperative day he developed pulmonary edema and abdominal distention. His total serum protein was 4.8. He was given 500 cc. of serum intravenously and the following day the pulmonary edema and distention were considerably less, the total protein having risen to 7.2. The next day, however, pulmonary edema and distention returned. Total protein determination at this time was 2.8. After another 500 cc. of serum were given, the pulmonary edema disappeared permanently and the total protein remained above 6.4.

This case illustrates that the giving of serum or plasma is substitution therapy and that the blood proteins will remain elevated permanently after the normal mechanism for their production has been reestablished.

The effects of giving a massive dose of concentrated serum to a normal individual were studied.[32]

Two hundred and fifty cc. of serum concentrated by the cellophane method from an original volume of 1,000 cc. were given intravenously to a normal adult. All chemical elements were concentrated to four times that of their original quantities. The serum was given slowly at the rate of 4 cc. per minute, all being injected in one hour. The sedimentation rate changes were of a minor nature. The total protein increased from 6.68 to 7.29 Gm., but the rise only lasted one hour. The total nitrogen changes were of a similar nature, from 1,100 mg. to 1,200 mg. The patient's blood albumin dropped markedly from 3.59 Gm. to 1.63 Gm. but returned to the previous level in an hour. No albumin was noted in the urine. The patient's blood globulin showed a marked increase for an hour, 3.09 Gm. to 5.66 Gm. The blood sugar dropped from 103 to 77 in one hour and remained low during the second hour. Although the hematocrit rose at the end of the second hour, the red blood cell count and the hemoglobin estimates seemed to indicate a dilution of the blood. Leukocytosis was marked at the end of one hour. Physiologic adaptation occurred. The changes seen were not major. It is possible that even a larger amount of serum given at the same rate would show no change. Giving the same or a larger amount more quickly would probably show greater differences. The blood pressure did not vary markedly. No untoward reaction was noted subjectively or objectively in this patient.

From this study, it would appear that large amounts of serum would have to be given in conditions associated with hypoproteinemia.

Conclusion

Normal liquid serum is a satisfactory substance for the treatment of burns and of shock without hemorrhage. It is of temporary value in shock resulting from blood loss. The dried forms of serum and plasma provide armed forces with emergency measures for the treatment of these conditions. The concentrated types provide products which can be used in hypoproteinemia.

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BIBLIOGRAPHY

1. Cannon, W. B.: Traumatic Shock, New York, D. Appleton and Co., 1923.
2. Blalock, Alfred: Experimental Shock, Arch. Surg. 20:959 (June) 1930.
3. Harper, S. B.; Essex, H. E., and Osterberg, A. E.: The Preparation and Experimental Use of Dried Blood Plasma, Proc. Staff Meet., Mayo Clin. 15:689 (Oct. 30) 1940.
4. Levinson, S. O.; Rubovits, F. E., Jr., and Necheles, Heinrich: Human Serum Transfusions, J. A. M. A. 115:1163 (Oct. 5) 1940.

5. Minot, A. S., and Blalock, Alfred: Plasma Loss in Severe Dehydration, Shock and Other Conditions as Affected by Therapy, Ann. Surg. 112:557 (Oct.) 1940.
6. Thalhimer, William: A Simple Inexpensive Method for Concentrating Serum under Sterile Conditions, Proc. Soc. Exper. Biol. & Med. 37:639 (Jan.) 1938.
7. Hartman, F. W.: Use of Cellophane Cylinders for Desiccating Blood Plasma, J. A. M. A. 115:1989 (Dec. 7) 1940.
8. Flosdorf, E. W., and Mudd, Stuart: Procedure and Apparatus for Preservation in "Lyophile" Form of Serum and Other Biological Substances, J. Immunol. 29:389 (Nov.) 1935.
9. Flosdorf, E. W., and Mudd, Stuart: An Improved Procedure and Apparatus for Preservation of Sera, Microorganisms and Other Substances—The Cryochem-Process, J. Immunol. 34:469 (June) 1938.
10. Flosdorf, E. W.; Stokes, F. J., and Mudd, Stuart: The Desivac Process for Drying from the Frozen State, J. A. M. A. 115:1095 (Sept. 28) 1940.
11. Hill, J. M., and Pfeiffer, D. C.: A New and Economical Desiccating Process Particularly Suitable for the Preparation of Concentrated Plasma or Serum for Intravenous Use: The Adtevac Process, Ann. Int. Med. 14:201 (Aug.) 1940.
12. Hill, J. M.; Muirhead, E. E.; Ashworth, C. T., and Tigertt, W. D.: The Use of Desiccated Plasma, J. A. M. A. 116:395 (Feb. 1) 1941.
13. Levinson, S. O.; Neuwelt, Frank, and Necheles, Heinrich: Human Serum As a Blood Substitute, J. A. M. A. 114.455 (Feb. 10) 1940.
14. Mayner, Frank: Death from Transfusion of Plasma, J. A. M. A. 116:2015 (May 3) 1941.
15. Mann, F. C.: Experimental Surgical Shock, Am. J. Physiol. 50:86 (Oct.) 1919.
16. Bond, D. D., and Wright, D. G.: Treatment of Hemorrhage and Traumatic Shock by the Intravenous Use of Lyophile Serum, Ann. Surg. 107: 500 (April) 1938.
17. Beard, J. W., and Blalock, Alfred: Intravenous Injections, J. Clin. Investigation 11:249 (March) 1932.
18. Mahoney, E. B.: Study of Experimental and Clinical Shock with Special Reference to Its Treatment by Intravenous Injection of Preserved Plasma, Ann. Surg. 108:178 (Aug.) 1938.
19. Whipple, G. H.; Smith, H. P., and Belt, A. E.: Shock as Manifestation of Tissue Injury Following Rapid Plasma Protein Depletion; Stabilizing Value of Plasma Proteins, Am. J. Physiol. 52:72 (May) 1920.
20. Daft, F. S.; Robscheit-Robbins, F. S., and Whipple, G. H.: Plasma Protein Given by Vein and Its Influence upon Body Metabolism, J. Biol. Chem. 123:87 (March) 1938.
21. Weech, A. A.; Goettsch, E., and Reeves, E. B.: The Effect of Serum Transfusion on the Plasma Protein Depletion Associated with Nutritional Edema in Dogs, J. Clin. Investigation 12:217 (Jan.) 1933.
22. Harkins, Henry: Treatment of Burns, Exhibit A. M. A., Cleveland (June 2) 1941.
23. Black, D. A. K.: Treatment of Burn Shock with Plasma and Serum, Br. M. J. (Nov. 23) 1940, p. 693.
24. Locke, E. A.: A Report of the Blood Examination in Ten Cases of Severe Burns of the Skin, Boston M. & S. J. 147:480 (Oct. 30) 1902.
25. Black, D. A. K., and Smith, A. F.: Blood and Plasma Transfusion in Alimentary Hemorrhage, Br. M. J. (Feb. 8) 1941, p. 187.
26. Elman, Robert: The Therapeutic Significance of Plasma Protein Replacement in Severe Burns, J. A. M. A. 116:213 (Jan. 18) 1941.
27. Schaefer, Arthur: The Treatment of Burns, Wisconsin M. J. 40:391 (May) 1941.
28. Trusler, H. M.; Egbert, H. L., and Williams, H. S.: Burn Shock, J. A. M. A. 113:2207 (Dec. 16) 1939.
29. Aldrich, C. A., and Boyle, H. H.: Concentrated Human Blood Serum as a Diuretic in Nephrosis, J. A. M. A. 114:1062 (March 23) 1940.
30. Thompson, W. D.; Ravdin, I. S., and Frank, I. L.: Effect of Hypoproteinemia on Wound Disruption, Arch. Surg. 36:500 (March) 1938.
31. Thompson, W. D.; Ravdin, I. S.; Rhoads, J. E., and Frank, I. L.: Use of Lyophile Plasma in Correction of Hypoproteinemia and Prevention of Wound Disruption, Arch. Surg. 36:509 (March) 1938.
32. Voigt, Philipp, and Hardgrove, Maurice: American Human Serum Association, Cleveland (June) 1941.

Sulfadiazine in Chronic Infections

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SULFADIAZINE (2 sulfanilamidopyrimidine) was described in 1940, and its chemical properties, effect on animals, and its first clinical use were presented in late 1940 and early 1941. There has barely been time since then for data to appear which will give a fair comparison with other sulfonamides, or for any unusual effects of the drug to become known.

In June, 1941, a supply of sulfadiazine was contributed by the Nepera Chemical Company of Yonkers, New York. It was intended to use this material for treatment of chronic, or resistant, or unusual infections, or conditions which seemed due to infection. The type of patient in residence at the Wisconsin General Hospital seemed most appropriate for, and limited to, such a purpose. The last few patients in this series were treated by sulfadiazine given by the Lederle Laboratories.

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Reported Qualities

The qualities of sulfadiazine will be mentioned only briefly.

The drug is rapidly absorbed from the intestinal tract, with some individual variation. Relatively high blood levels may therefore be obtained quickly. These are maintained by the slow excretion of the drug, chiefly through the kidney. A test for blood sulfadiazine is readily available. Conjugation of the drug in the blood is slight, and this form (acetylated) is readily excreted. The acetylated product is more soluble in the urine than most sulfonamides, which helps prevent obstruction in the tract. The drug passes readily into the cerebrospinal and other body fluids. These properties are the equal, or superior, of the other sulfonamides, especially sulfathiazole.

The drug is remarkably well tolerated. With average blood levels, only 5 to 10 per cent of patients have been reported to show toxic reactions. Central nervous system, gastrointestinal (including nausea and vomiting), and cutaneous signs and symptoms are uncommon. Bone marrow depression is rare. Hematuria (1 per cent), nitrogen retention, and crystaluria (10 per cent) are infrequent. Sulfadiazine is probably less than one-third as toxic as sulfathiazole. In one reported series, use of the drug never had to be discontinued.

Serious complications may occur only occasionally, but their rarity should not prevent the use of all controls and precautions.

Reported Efficiency

The specific uses of sulfadiazine may be briefly mentioned. It is as efficient or better than other sulfonamides (exclusive of its low toxicity, etc.,) in treatment of the acute coccal pneumonias, the coccal meningitis, erysipelas, and acute gonococcal arthritis. It has been useful in acute sinus infections and acute urinary tract infections (especially those due to colon bacillus). It has been used with effect in a nasal spray for colds, in operative incisions, in ointments for skin infections, in an oil base for burns, and in wounds.

Chronic infections have been less frequently or successfully treated. Chronic urinary and respiratory tract infections are said to be unaffected; chronic gonococcal arthritis was poorly responsive; and subacute bacterial endocarditis has not been influenced. A few cases of actinomycosis have been cleared by sulfanilamide, but sulfadiazine has not been reported in this usage, nor has it been reported in other fungus infections.

The Drug

The sulfadiazine tablets used in this series were 7.5 grains each. Alkalis were not used. Fluids were forced. The usual prescription for adults was 2 Gm. Stat.; 1 Gm. every four hours for twenty-four hours; 1 Gm. every six hours (or four times a day) thereafter. Blood concentrations were determined at twenty-four hours, and at three-day intervals thereafter during treatment. Complete blood counts and urinalyses (including a search for crystals) were obtained before the drug was used, after twenty-four hours, and every three days thereafter. (A heavy schedule of liver and kidney function tests was started, in a few cases, until it was decided that the objects of the experiment were gross tolerance and effect of the drug.)

The optimal therapeutic range for sulfadiazine is said to be between 5 and 15 mg. per cent. Our levels were almost always between these figures, and often were just below 10.

The cost of sulfadiazine is still relatively high. In the Hospital pharmacy at present, sulfanilamide costs 1.5 cents per tablet; sulfathiazole 2.7 cents; sulfadiazine 10 cents (a recent decrease from 15 cents).

Present Usage

The following heterogenous conditions were treated according to the methods described. The approximate effect of sulfadiazine was estimated in each case.

The drug was also used in ten acute respiratory infections in normal, thyrotoxic, or tuberculous individuals. It failed to change the course of the cold in any case.

It was used in five others to prevent secondary respiratory infections, and only one developed a sinusitis.

CONDITION	EFFECT		
	Good	Possible	Poor
1. Pemphigus vulgaris			X
2. Pemphigus vulgaris		X	
3. Actinomycosis—jaw	X		
4. Actinomycosis—neck	X		
5. Subacute bacterial endocarditis			
6. Pneumococcus VI			X
7. Streptococcus viridans		X	
8. with rheumatic heart		X	
9. with congenital heart			X
10. Rheumatic fever		X	
11. Chronic ulcerative colitis		X	
12. with rectal abscess		X	
13. Chronic multiple (Staph.) infections			X
14. Cellulitis of the jaw—postoperative	X		
15. —preoperative	X		
16. Carbuncle and furunculosis	X		
17. Monilia pneumonitis with cavitation	X		
18. Putrid empyema and pneumonitis			X
19. Subacute bronchiectasis and pneumonitis	X		
20. Unresolved pneumonia		X	
21. with lymphosarcoma		X	
22. with atelectasis			X
23. Miliary abscesses of lung	X		
24. Tracheotomy cellulitis			X
25. Chronic bronchitis—Pneumococcus III			X
26. —Pneumococcus XIII			X
27. Bronchial pneumonia	X		
28. with pleurisy	X		
29. Lobar pneumonia (Type I)(laboratory infection)	X		
30. Chronic pneumonitis with congenital atelectasis			X
31. Postoperative pericardial empyema (Staph.)			X
32. Post-pneumonectomy empyema		X	
33. Post-thoracoplasty wound infection			
34. Staph. aureus			X
35. Staph. aureus		X	
36. Staph. aureus			X
37. prophylaxis		X	
38. extrafascial empyema	X		
39. Hyperplastic laryngitis			X
40. Secondary infection in tuberculous knee			
41. Osteomyelitis of the foot			X

Fifteen of the patients in this series had a coincidental tuberculosis. No modification of this condition was noted.

Tolerance and Toxicity

Complete records of blood and urine findings were kept in 35 cases. Signs and symptoms were regularly noted in a few more (47 cases).

Tolerance for sulfadiazine was noted to be perfect in 86 per cent. Slight nausea was present due to the drug in 6 per cent and due to the illness in 6 per cent. The drug was discontinued in one case due to nausea, malaise, and a rash. There was no relationship of symptoms to the sulfadiazine blood levels. It was necessary to rule out distention, delirium, urticaria, restlessness, and suicidal tendencies (1 case each) as symptoms due to the drug, but this was easily possible.

Signs due to the drug were absent in 98 per cent of the patients. A diffuse rash (see case I) occurred in 1 patient. No patient had any appreciable cyanosis.

Fever was unchanged in 28 per cent, decreased due to the drug in 53 per cent, coincidental in 6 per cent, increased due to the drug in 5 per cent, and coincidental in 8 per cent.

The hemoglobin and red blood cell count were affected synchronously. Only 9 per cent had a questionable slight depression in the levels. The white blood count was depressed to about 5,000 in 3 cases, but there was no sign of greater neutropenia.

Unusual urinary findings were occasionally present. One case (3 per cent) had

sulfadiazine crystals present on one occasion. Four cases (13 per cent) had RBC and/or a positive test for benzidene.

Twenty cases had been given another sulfonamide previous to sulfadiazine. In three of these the tolerance was not known. One case was intolerant to sulfapyridine, tolerant to sulfadiazine. Of the 16 cases given sulfathiazole, half had been intolerant to that drug, all were tolerant to sulfadiazine.

Case Reports

Six cases seem worth mentioning briefly.

Case I. A white male, aged 45 years, was admitted for excision of anal fistula. Had a mild cough and roentgenogram showed a few stringy patches in lungs. He was readmitted three months later after two weeks in another hospital because of acute pleurisy, fever, and cough. He had a fever of 100.6F, 180 cc. of purulent sputum, multiple soft areas in both lungs with multiple cavities, shown by roentgenogram, the largest of which was 2 by 3 cm. The sputum contained Streptococcus viridans and a yeastlike organism identified as Monilia albicans. Sulfadiazine was given for twenty-six days. The tolerance was perfect, with blood levels 7.2 to 9.4 mg. per cent. The urine showed a few RBC, but no crystals, and pus cells which were cleared. His fever cleared, his sputum decreased to 7 cc. in twenty-four hours and was negative, his racking cough disappeared, and the lung lesions decreased 75 per cent with all of the cavitation absent. He was discharged to continue on half-size doses of the drug until reexamined. The diagnosis was considered possibly to be moniliasis with multiple lung abscesses.

Case II. An obese, white male, age 35 years, was admitted with racking productive cough, severe dyspnea and cyanosis, and a fever of 102F. The illness was said to have begun abruptly eight days previously, though he may have had a mild cold two days before that period, and even felt less strong in the previous few months. Oxygen by nasal catheter was started. The sputum measured 20 to 40 cc., was purulent, and contained only nonhemolytic Streptococci. A roentgenogram showed a diffuse nodulation, 2 to 5 mm. in size, throughout both lungs. Râles and rhonchi were heard variably in many areas. Because the onset, the endobronchial symptoms, and the dyspnea seemed unlike miliary tuberculosis, sulfadiazine was given for twenty-five days. The temperature decreased to normal inside of three days, the sputum decreased to 1 cc. of mucoid material, the pulse, respiratory rate, dyspnea and cyanosis cleared slowly, due to the slow but regular clearing of the lung lesions which were 90 per cent gone as shown by roentgenogram at the time of discharge. The diagnosis was considered to have been miliary pneumonia or abscesses.

Case III. A white male, aged 43 years, had a subacute, submaxillary abscess which was incised and found to contain pus from which was smeared and cultured Actinomyces bovis. Sulfathiazole was given abortively, before the diagnosis or incision, with no effect. After the diagnosis, sulfadiazine was given for fifteen days. The patient was ambulatory. Through a misunderstanding, he took double the usual dose in the first thirty-six hours, but tolerance was perfect then and later. Blood levels were maintained between 10.9 and 7.6 mg. per cent, the urine was clear, the WBC changed from septic to normal, and the lesion closed and healed uneventfully. It has remained so for ten months without prolonged medication.

Case IV. A white female, aged 23 years, had chronic pulmonary tuberculosis with an ineffective thoracoplasty. A revision thoracoplasty was done; the fever increased seven days after operation; an extrafascial loculation of pus was noted, aspirated, and the diagnosis of Staphylococcus aureus infection was made. Sulfadiazine was given by mouth, and the fever dropped after the first day. The space was aspirated and irrigated daily, sodium sulfathiazole being used after the third day. The space was sterile in one week. On the thirteenth day the patient noted nausea, malaise, fever, and a scarlatiniform rash. The drug was stopped and all signs and symptoms subsided.

A second revision operation was done a week later, and after forty-eight hours sulfadiazine was started (in 1 Gm. doses every four hours) as a prophylactic. After two doses the patient again exhibited the same signs and symptoms of the first course. These subsided promptly when the drug was discontinued. No infection occurred; the blood and urine showed no sign of drug effect.

Case V. A white male, aged 35 years, was unwittingly exposed for half an hour to a spray of virulent type I Pneumococci from a laboratory centrifuge. Three other individuals were also in the room. Positive cultures were obtained from objects throughout the room. Sulfadiazine was given to all four for a period of five to seven days, with no knowledge of how long such a period should really be. Two had no symptoms or signs, nor changes in the blood or urine. One had a mild headache and leukopenia on the fifth day. The patient had a transient fever and chilliness on the fifth day and continued the drug for two days more without incident.

Fourteen days later he was seen and was well. That evening he felt chilly while sitting outdoors; at 11 p. m. he had a recurrence, with a fever; at 2 a. m. he had a frank chill, a fever of 102F, nausea and vomiting, but no lung symptoms. At 7:30 a. m., after symptomatic therapy, he had a normal temperature. At 8:15 he had a fever of 102.8F, dry cough, and was immediately given sulfadiazine and taken to the hospital. A bedside film at 9:30 a. m. showed early lateral left basal consolidation. He was stuporous, his fever rose to 105F by evening, but his cough was dry. The next morning his temperature

was 98.4F, and it never rose above that subsequently. The cough never became productive. Swabs of the throat and typing against the urine showed type I Pneumococcus. The roentgenograms showed a small increase in consolidation after two days, a 50 per cent clearing in six days, and only a few truncal strands after two weeks. He was discharged on the tenth day but continued to take small doses of the drug for three weeks. The tolerance was perfect at all times. It was doubly fortunate that the drug was available, since specific antibodies were absent from his blood after exposure, during, and two weeks after the pneumonia.

Case VI. A white male, aged 48 years, had a condition diagnosed as subacute bacterial endocarditis lenta, in the presence of rheumatic heart disease with myocardiac degeneration and auricular fibrillation. Blood cultures were positive for Streptococcus viridans. Sulfadiazine was given according to the usual schedule, except that the dosage was not reduced after twenty-four hours. On the seventh day a blood sulfadiazine was 39 mg. per cent. During this period the tolerance was good, the urine was clear, the WBC became slightly less septic, and the fever became normal and remained so after the second day. When the high blood concentration was found, one of the staff gave intravenous fluids to hasten elimination by kidneys. Cardiac decompensation and death abruptly occurred. All of these occurrences may have been coincidental, but it is notable that control of dosage may be difficult even in a carefully planned usage.

Summary and Conclusions

Sulfadiazine is a valuable drug. The results at Wisconsin General Hospital confirm the reports in the literature of its success.

It is effective in many chronic or subacute infections. Its lack of effect in others may be of help in differential diagnosis. Some of the conditions in which the drug is ineffective were virus, or possible virus, infections, Streptococcus viridans infections, inflammations containing saprophytic organisms, and walled off chronic lesions, often containing Staphylococci.

Tolerance of average blood levels is excellent with symptoms, signs, depression of bone marrow, irritation or obstruction of the urinary tract being rare. Tolerance is better than for other sulfonamides, according to reports, and sulfadiazine was tolerated in numerous cases where other sulfonamides were not.

A therapeutic blood concentration can rapidly be attained and maintained by the routine described.

Special watchfulness for toxic effects is necessary because of their very rarity and the apparent innocuousness of the drug. It is best given where dosage can be regulated and blood concentration, blood counts, and urinalyses determined, but its margin of safety makes less controlled usage legitimate.

This trial use of sulfadiazine has been of value to our hospital in providing firsthand knowledge of its effects and limitations.

Authors' Note: The authors wish to express gratitude to the Nepera Chemical Company and to the Lederle Laboratories for the supply of sulfadiazine they have so generously provided.

Some Psychologic Aspects of Medical Disorders*

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STUDY of medical disorders from the psychologic point of view is one of the oldest and also one of the most recent of various approaches to the investigation of physical disease. The ancient writers recognized that emotional factors played a part in causing ill health, and they debated what relationship body and mind held to each other. Hippocrates wrote of the necessity of recognizing the whole man, and Galen, also adhering to this point of view, emphasized the importance of understanding the human organism as an entity and of not being misled into treating symptoms. Physical reactions to emotional difficulties were known. Aretaeus, for example, stated, "The offspring of pleasure are good digestion, good condition, and good colour of the body; of disgust, their contraries." Galen, in discussing why other physicians had made mistaken diagnoses in two cases he reported, said, "I suppose it is because they have no clear conception of how the body tends to be affected by mental conditions. Possibly also

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they do not know that the pulse is altered by quarrels and alarms which suddenly disturb the mind." More extensive investigations are being conducted today, but the problems are essentially the same, and with the aid of modern resources the role of the emotions in causing physical ill health is being studied.

Much of the stimulus to the present interest in psychologic aspects of illness originated during the last war. A better appreciation of the significance of emotional factors and the opportunity to study individuals who had been subjected to great stress made it clear that many of the medical casualties were suffering from disorders initiated in large part by emotional disturbances. The syndrome known as disordered action of the heart was separated from organic heart disease. Transient disturbances of systolic blood pressure up to 180 mm. of mercury were observed in healthy soldiers admitted to the hospital immediately after a fierce bombardment, while more prolonged hypertension was noted in individuals with neurotic personalities. Stress dyspepsia was a condition frequent among the gastrointestinal disorders and was often followed by peptic ulcer. There was a high incidence of toxic goiter. These are described in "The Neuroses in War."[1] At the present time, studies are being devoted to such medical conditions as asthma, arthritis, peptic ulcer, and hypertension. The investigations which are conducted combine the careful evaluation of the physical status, the applications of the methods of the laboratory, and the understanding of the emotional factors which modern psychologic concepts make available. It is not the purpose of these studies to show that psychologic factors are the prime and only cause of organic disease, but, rather, to understand the part they play in initiating and maintaining bodily conditions which, when long continued, may result in irreversible organic changes.

Emotions Cause Physical Reactions

The evidence is so readily available that probably no one will categorically deny that emotions can cause physical reactions. When a person is amused to the point of laughter, tears may come. Worry produces lack of appetite and even dyspepsia. Anger or fear can cause increase in cardiac rate and force. Sudden fright will produce this result in any normal person, and, if the threat to life has been great, clammy sweat, dryness of the mouth, nausea, diarrhea and urination may occur. Perhaps the most revealing example of an emotionally determined physical reaction is the way in which an individual's facial expression changes with his emotional state. A person coming to a doctor to have such simple surgical procedure as the incision of an abscess will show a variety of changes in interesting succession. Unconsciously the pupils will dilate and the eyes will widen as he portrays apprehension while the physician makes the examination and paints the infected area. His brows will knit and teeth clench when he feels the pain as the incision is made, and finally there will be relaxation and relief when he realizes that the operation is over and there will be no more hurt.

The Philosophy of Descartes

The separation between body and mind and the emphasis in scientific investigations that there are these two distinguishable entities are generally attributed to the philosophy of Descartes. He was influenced by the scientific discoveries of the seventeenth century, in which he lived, and formulated the philosophy that God created two substances, mind and body, which had such different qualities that they could not possibly affect one another. He explained the harmony between the two by postulating that they were synchronized so that an activity of the one was accompanied by a corresponding activity of the other.

This division of the human organism into two independently operating systems has been extremely useful in dealing with scientific problems. It is still the premise on which a large part of medicine is based, for medical therapy is instituted on the assumption that the body functions mechanically, and that when a certain material stimulus is applied, a definite and predictable result will follow. We know, for example, that if insulin is given, the blood sugar will fall.

We are not able, however, to predict precisely how much it will fall, and it is only within rather wide limits that we can prognosticate the effects of other things we do, for this apparent mechanical functioning of the body is only true up to a certain point. The same drug is not always equally effective at different times in the same individual. This is clearly seen in the nervous patient, in whom the amount of sedative necessary to induce sleep varies with the degree of tension the patient is under at the time the medication is given. The way in which the body itself reacts to stress may also vary. It has been noted by many observers that migraine, after recurring periodically for many years, may cease, and the patient may become subject to such organic reactions as paroxysmal tachycardia, epilepsy, or emotional disorders such as phobias and depression.

Allergic reactions may cease in the presence of some other disorder. At the time his hay fever usually occurred, a patient who had been subject to hay fever regularly each summer was under observation because of a paranoid psychosis manifested by a variety of delusions of persecution. Despite the fact that it was the time of year when he ordinarily had his hay fever, it did not appear. He remarked on its absence, and stated that, although it had been extremely bothersome to him, he would much prefer it to the difficulties from which he was then suffering. It is interesting to note that in this individual, although the hay fever did not occur, skin tests reacted positively to pollens that had previously produced his allergic reaction.

Strength of Emotions Not Recognized

The failure to recognize the strength of emotions is one reason for neglecting their significance in producing physical illness. Feelings are usually so well concealed, and individuals seem to operate so much more by reason than emotion, that it is often difficult to appreciate the importance of psychologic forces. In the nervous person, in whom feelings have gotten out of hand, one may readily see how fear, jealousy, anger and so on are at work, for they are clearly expressed in the patient's attitude, thinking and actions. But, in the normal person, such forces are usually not immediately apparent. This is not because they are lacking, but because they are repressed or find outlet in some useful form. Glover[2] compared the mind with its conscious and emotional aspects to a small boy riding an elephant. The boy thinks that he has control of the situation, whereas actually he has to go where the elephant wishes. Likewise, although intellect and reason seem to determine our activities, the emotions are powerful forces which can decide our aims. Parents, for example, will often sacrifice many things in order that their children may have advantages they themselves lacked. Fear of poverty known in childhood may be so threatening that an individual will devote his whole life to providing such security for himself that he will never lack material things, and the necessity of being better in some way than an envied brother or sister may drive a person to excel in his field.

Somatic Responses to Emotional Stimuli

Many investigations have been conducted on both animals and man to determine the somatic responses to emotional stimuli. Among the best known animal experiments are those of Cannon[3] and his associates, who observed the chemical and physiologic responses in cats after they were exposed to barking dogs. They observed that in addition to the directly noticeable reactions such as dilatation of the pupils, erection of the hair on the back and tail, increased motor activity and restlessness, there were other internal reactions. Movements of the stomach and intestines were inhibited; there were increased amounts of adrenin in the blood; glycosuria occurred, and the blood sugar was elevated; the coagulation time decreased, and there was an increase in the erythrocyte count. Beaumont[4] wrote in 1847 from his experiments on Alexis St. Martin, ". . . (In) fear, anger, or whatever depresses or disturbs the nervous system, the villous coat (of the stomach) becomes somewhat red and dry, at other times, pale and moist and loses its smooth and healthy appearance; the secretions become vitiated, greatly diminished, or entirely suppressed;

the mucous coat scarcely perceptible; the follicles flat and flaccid, with secretions insufficient to protect the vascular and nervous papillae from irritation." Contemporary investigators have added their observations of the reactions of different systems to emotional stress. Alvarez[5] reported on psychologic factors causing disturbances in the digestive tract. Stokes[6] has written about the dermatoses which have an emotional causation. Wolfe,[7] Thomas,[8] and Bram,[9] respectively, have described the relationship of psychic elements and cardiac disorder, arthritis, and hyperthyroidism. Wittkower,[10] in a lengthy monograph with a full biography, has shown that as a result of emotional disturbances, changes may occur in the respiratory, gastrointestinal and cardiovascular systems, in the quality and amount of urine secreted, in the blood, and in endocrine function. In one series of experiments, he observed that emotions exercise an influence on biliary secretion. The experiments were conducted by deeply hypnotizing the patients, giving suggestions which caused joy, sadness, fear and anger, and observing the changes in the amount of bile secreted while the individuals experienced these different emotions. Twenty experiments showed that joy, sorrow and fear had a stimulating effect on the bile. The effect became obvious almost coincidently with the beginning of suggestion and faded out just as quickly. When the patient was angry, the biliary secretion was entirely or almost entirely inhibited. Wittkower felt that there was probably a combination of inhibited production and spasm of the bile ducts. He concluded that: (1) Certain sensations in the right upper region of the abdomen after anger may be plausibly explained as spasm of the bile ducts; (2) The digestion of the angered individual is apt to take a course similar to that in obstructive jaundice; (3) Psychologic factors may assist in the origin of jaundice and, perhaps, also of gallstones.

Effect on Spasm of the Esophagus

A somewhat similar study to that of Wittkower has been conducted by Faulkner,[11] who reported on twelve cases in which spasm of the esophagus was studied by esophagoscope. The spasm could be increased and the esophageal lumen narrowed or closed by suggestions that caused emotions such as grief, fear, anger and apprehension; the spasm could be relaxed and the lumen widened immediately through suggestions causing feelings of happiness, contentment and security. The suggestions made were determined by first taking a careful social history and then selecting situations which had a particular meaning for the patient. Thus, in one woman who had been divorced and had lost the custody of her child, the suggestion that she might never see her boy again caused instantaneous spasm and complete closure of the lumen of the esophagus, while the suggestion that she might have him permanently brought a prompt relaxation of the spasm and return of the lumen to normal size, twice as large as was noted at the beginning of the examination.

Effect on Peptic Ulcer and Duodenitis

Among the latest experimental work is that of Mittelmann and Wolff.[12] They examined a series of 30, unselected patients with peptic ulcer and duodenitis. From the history of each of these patients, they were able to learn of the situations which were peculiar to each individual in producing intense anxiety, insecurity, resentment, guilt and so on. When these emotions were aroused in the laboratory by discussing with the patients the life situations which initiated them, there was almost always an increase in hydrochloric acid, mucus and pepsin secretions; peristaltic activity became continuous, and contractions increased in magnitude. Often, in patients with ulcer, pain of a burning and gnawing quality was precipitated, and unusual amounts of bile and moderate amounts of fresh, unclotted blood appeared in the extractions. During and after interviews which engendered emotional security, functional overactivity decreased and approached normal. A comparison of the individual psychologic and emotional changes in normal subjects with those of patients with ulcer, gastritis and duodenitis, revealed similar patterns, but the changes in the pathologic group were greater in magnitude and duration.

Effect on Smooth Muscles and Glands

Cannon[3] states that when a cat becomes frightened, "the pupils dilate, the activities of the stomach and intestines are inhibited, the heart beats rapidly, the hairs of the back and tail stand erect—from one end of the animal to the other there are abundant signs of nervous discharges along sympathetic courses." Similarly, in man under emotional stimulation, the physical reactions are produced by the activity of the autonomic nervous system on smooth muscle and glands. This is well seen in the anxiety states, of which chilliness, pallor, cold sweat, palpitation and dyspnea are prominent symptoms, but the visceral and glandular disturbances which constitute many medical disorders are produced in the same way. Fetterman[13] draws attention to the importance of the diencephalon in this regard as the center where emotions are "physiologized" and from which impulses reach the viscera by the vagal and sympathetic pathways.

Effect on Organic Functions

Dunbar[14] quotes Alkan as stating that emotionally conditioned responses on contractile elements may lead to organic changes in any one of four ways. First, a circular spasm in hollow organs produces an anemia with lack of nutrition and resulting cell damage in the part involved. In the stomach, such a reaction will produce a peptic ulcer, while in the colon, it will result in ulcerative colitis. Second, lasting or sufficiently often repeated spasm of tubular organs leads to muscle hypertrophy of the superior parts with secondary dilatation. Examples are dilatation of the esophagus and hypertrophy of the left ventricle in essential hypertension. Third, when the spasm in tubular organs produces stasis in fluids which normally circulate freely, there will be pathologic changes in these fluids through alteration of concentration or through fermentation. This may result, for example, in a solitary cholesterone stone of the gall bladder. Finally, if above a long-lasting circular spasm there happens to be infectious material which ordinarily, because of its unhindered passage, produces no clinical symptoms, the infected fluid is dammed up under increasing pressure and causes a febrile, purulent inflammation which may lead to perforation or thrombosis. An example is infection in gall bladder obstruction.

One of the difficulties in recognizing the significance of psychologic factors in the causation of disease is that the patients usually protest having any emotional disturbance and contrive to present themselves as well integrated, adequate and controlled individuals. The suggestion that they might have been unable to cope adequately with certain life situations is often denied by them, and there is rarely any admission that they have misgivings about their abilities to react well under stress. Since it is an important function of the personality to maintain a sense of satisfaction with oneself, it is not surprising that there is some psychologic blindness to personal conflicts, but, despite the patient's denials that he has been unduly disturbed, the history will often reveal that ill health has been concomitant with emotional difficulties. The observation is not unusual, for example, that the severity of organic conditions such as diabetes, cardiac decompensation and hypertension fluctuate with the emotional state of the patient. Given security and peace of mind, the organic disorder is less pronounced; faced with anxiety and dissatisfaction, it becomes intensified. Mittelmann and Wolff[12] observed that their patients rarely complained of emotional distress or personality problems, and that superficial contact might lead to the conclusion that they were well adjusted persons. The authors note, however, that "in all the patients with peptic lesions it was possible to demonstrate a chronological parallelism between the onset, recrudescence and course of gastro-duodenal symptoms and the occurrence of untoward emotional reactions."

Significance of Environmental Problems

The problems which beset the individual and produce the tensions manifested in somatic ways are those of everyday living and, although they may have deep psycho-

logic significance, are in themselves commonplace affairs. Environmental stress, especially poverty, grief and family worry, were thought by Cobb, Rauer, and Whiting[15] to bear more than a chance relationship to the onset and exacerbations of rheumatoid arthritis in a group of cases they studied. Nissen,[16] also writing on arthritis, pointed out that although there was no one etiologic agent, many patients had been so conflicted by "unexpressed rebellion against life as it was meted out to them; work when they wanted schooling; repeated, unwished-for child bearing; longing for the big things in life when obviously the little things must be that individual's portion"; that there was "more than sufficient background to produce a body revolt, either cataclysmic, or slow, insidous, and progressive." The stresses of presumably successful living may also contribute to ill health. The matron who carries out her social duties quite adequately sometimes does so at the expense of suffering strong feelings of inferiority and a sense of being criticized by others. The business man may achieve his goal of success by carrying the whole burden of responsibility and worrying over each problem, whether large or small, which arises. Even the apparently innocuous experience of living away from home is frought with anxiety for some.

These situations, many of which are quite dissimilar, can only be understood by the individual who experiences them. The significance of the situation may be masked by its general nature or by its apparent implications of good fortune and yet arouse intense feelings of resentment, frustration, or some other dissatisfaction in the person who meets them. When these feelings are not outwardly expressed but discharged, as it were, through autonomic channels, some somatic response will occur. When the emotional difficulties have to be met over months and years, it is inevitable that the tension will produce a state of altered function, which will eventually result in irreversible organic change.

BIBLIOGRAPHY

1. The Neuroses in War, edited by Emanuel Miller, New York, The MacMillan Co., 1940.
2. Glover, E.: Lectures on Technique in Psychoanalysis, Internat. J. Psycho-Analysis 8:311 (July) 1927.
3. Cannon, W. B.: Bodily Changes in Pain, Hunger, Fear and Rage, ed. 2, New York, D. Appleton & Co., 1929.
4. Beaumont, W.: The Physiology of Digestion, ed. 2, Burlington, Vermont, C. Goodrich, 1847.
5. Alvarez, W. C.: Ways in Which Emotion Can Affect the Digestive Tract, J. A. M. A. 92:1231 (April 13) 1929.
6. Stokes, J. H.: Functional Neuroses as Complications of Organic Disease, J. A. M. A. 105:1007 (Sept. 28) 1935.
7. Wolfe, T. P.: Emotions and Organic Heart Disease, Am. J. Psychiat. 93:681 (Nov.) 1936.
8. Thomas, G. W.: Psychic Factors in Rheumatoid Arthritis, Am. J. Psychiat. 93:693 (Nov.) 1936.
9. Brann, I.: Psychic Trauma in the Etiology of Graves' Disease, Am. J. Psychiat. 92:1077 (March) 1936.
10. Wittkower, E.: Studies on the Influence of Emotions on the Functions of the Organs, J. Ment. Sc. 81:533 (July) 1935.
11. Faulkner, W. B., Jr.: Objective Esophageal Changes Due to Psychic Factors, Am. J. M. Sc. 200:796 (Dec.) 1940.
12. Mittelmann, Bela; Wolff, H. G.: Emotions and Gastroduodenal Function: Experimental Studies on Patients with Gastritis, Duodenitis, and Peptic Ulcer, Psychosom. Med. 4:5, 1942.
13. Fetterman, J. L.: The Correlation of Psychic and Somatic Disorders, J. A. M. A. 106:26 (Jan. 4) 1936.
14. Dunbar, H. Flanders: Emotions and Bodily Changes, New York, Columbia University Press, 1935.
15. Cobb, Stanley; Bauer, Walter, and Whiting, Isabel: Environmental Factors in Rheumatoid Arthritis, J. A. M. A. 113:668 (Aug. 19) 1939.
16. Nissen, H. A.: Chronic Arthritis and Its Treatment, New England J. Med. 210:1109 (May 24) 1939.

BY-LAWS, CHAPTER VIII, SECTION 1

". . . Any member whose name has not been reported for enrollment and whose dues for the current year have not been remitted to the secretary of this Society on or before March 31 shall stand suspended until his name is properly reported and his dues for the current year properly remitted."

Comments on Treatment

Editors—A. J. QUICK, M. D., Marquette University, Milwaukee, and
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The Rh Blood Factor

The Rh blood factor was discovered in 1940 and so named by Landsteiner and Wiener when they found that the sera of rabbits immunized against the blood of Macaco rhesus monkeys would not only agglutinate the blood of the monkeys but also the blood of about 85 per cent of human beings, regardless of their blood group. Later work brought out the significance of this factor in the development of erythroblastosis fetalis, certain complications of pregnancy, and certain transfusion reactions.

The Rh factor is an antigenic substance in human blood similar to the factors A and B which determine the blood groups, but unlike the latter is apparently present only in the red blood cells and there are no normal agglutinins against it. Agglutinations due to the Rh factor are not demonstrable by the usual typing and cross matching tests so that special tests must be carried out. About 85 per cent of the general population is Rh positive, i.e., the Rh factor is present in the blood, and 15 per cent is Rh negative. The Rh factor is inherited as a nonsex-linked mendelian dominant characteristic, and in matings where both parents are Rh negative, all children should be Rh negative. In matings where the father is Rh positive and the mother Rh negative, at least 50 per cent of the offspring will be Rh positive.

About 90 per cent of the studied cases of erythroblastosis fetalis, which includes fetal hydrops, icterus gravis neonatorum, and anemia of the newborn, can be explained on the basis of isoimmunization to the Rh factor. Isoimmunization denotes immunization within the same species, and it is postulated that the red blood cells or the Rh factor of an Rh positive fetus who inherited the factor from an Rh positive father pass through the placenta into the maternal circulation, a situation which in certain Rh negative women results in the formation of anti-Rh agglutinins in the mother. These anti-Rh agglutinins of the mother are transferred to the fetus where they cause hemolysis of its blood, which is the fundamental process in erythroblastosis fetalis. There is definite proof of the existence of the anti-Rh agglutinins in such maternal blood, and there are indications that they may also be present in the breast milk. There is also considerable evidence that many stillbirths, abortions, miscarriages, etc., are the result of such a reaction. Therefore, the proper setup for such occurrences is an Rh negative mother and an Rh positive fetus with an Rh positive father, but it should be pointed out that not all such combinations end in trouble.

As to treatment under the circumstances when blood transfusions are so frequently necessary, it cannot be emphasized too strongly that the utmost care must be exercised. There are indications that the fetus does better when transfused with Rh negative blood, at least for about the first ten days. It might also be wise to consider removal of the infant from the mother's breast milk. To avoid a possibly fatal transfusion reaction in such a mother, it is imperative to give her Rh negative blood and by no means blood from her husband.

The only other known time that the Rh factor enters the picture in blood transfusions is subsequent to repeated transfusions given to the same patient when he or she is Rh negative. Regardless of the proper typing and cross matching of bloods by routine methods, when an Rh negative recipient receives repeated blood transfusions of Rh positive blood, he may develop anti-Rh agglutinins, and then any subsequent Rh positive blood given to him may result in a severe or even fatal reaction. Therefore, when repeated transfusions are given to any patient, one should know the Rh status of the bloods, which is determined by special methods.

In summary then, it may be said that the Rh factor is an antigenic substance present in the red blood cells of about 85 per cent of the random population. There are no known normal agglutinins against it, but some Rh negative individuals do develop anti-Rh agglutinins when given contact with Rh positive blood. Such isoimmunization may develop in relation to certain conditions involving pregnancy and repeated blood transfusions to the same individual. In such relationships it is always an Rh negative individual who develops anti Rh agglutinins in response to contact with Rh positive blood. Reactions where they occur are severe and often fatal. These agglutinations do not usually show up in routine cross matching and require special technics. L. W. SCHAEFER.

Industrial Absenteeism*

By MR. ANDREW T. COURT**
Detroit

MR. A. T. COURT

AN INCREASING burden of personal lost time has usually accompanied periods of full employment in the history of modern industry. During the height of the previous World War effort, absenteeism from shipyards averaged 20 per cent. The first chart shows how this sort of thing began to cut down the efficiency of American industry about the time we entered the war. Recently, the British press has discussed at length special measures designed to deal with excessive lost time there. It is worthy of serious study.

You will note from the second chart that we in General Motors have seen short-term absenteeism double during the last fifteen months. Today, our individual plants show total lost time rates varying between 2 and 6 per cent. The importance of this problem is apparent when you consider that a 5 per cent loss of time for personal reasons may reduce production 15 per cent or more, because the absence of individual specialists breaks up the balance of skills necessary to secure maximum group efficiency. Modern American industry with its highly tooled, closely scheduled operations naturally suffers more from a given proportion of unscheduled absences than would less fully developed manufacturing.

I have a few charts which may be of some interest to you in sizing up the problem. Although many of the figures I shall present

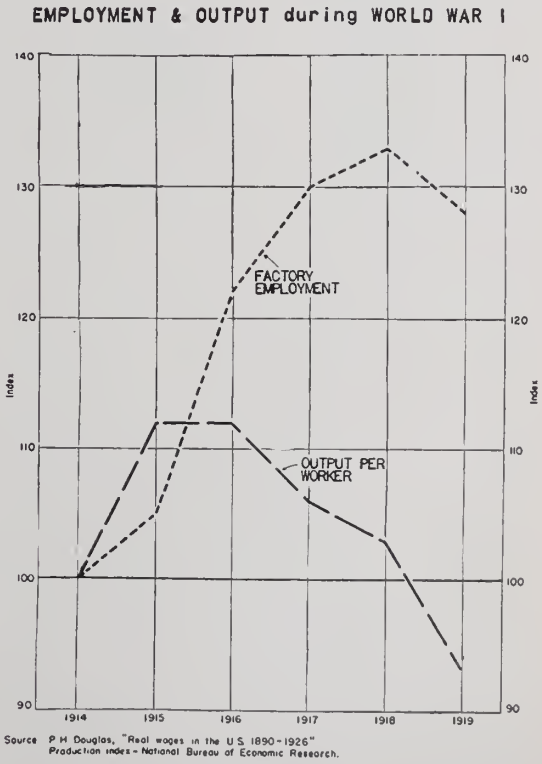


Chart 1

* Presented before the Postgraduate Industrial Medical and Surgical Clinic of the State Medical Society of Wisconsin, Milwaukee, November, 1942.
** Labor Economist, General Motors Corporation.

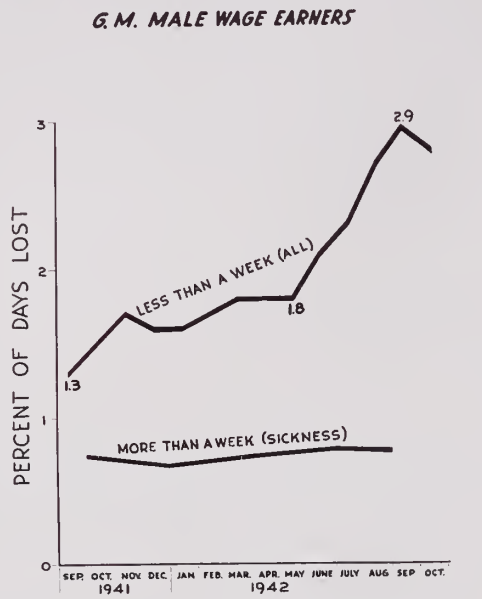


Chart 2

refer to General Motors, the comments and opinions are entirely my own.

The first question that arises is that of the workers' health. Specifically, does this increased absenteeism which we have noted reflect generally poorer health? You will note immediately from the chart that, although the short-term personal lost time shown by the top line has doubled, the serious sickness of more than a week shows no upward trend. Before reaching any conclusion, one must remember that in normal peacetime years, there is usually a summertime decline in sick disability rates. Relative to the normal seasonal pattern, we may be witnessing the first signs of a significant increase in more serious sick absenteeism. It is too early to form any definite conclusion.

We are fortunate in the fact that this country has, so far, escaped war-borne epidemics, restriction of food supply, or any widespread serious overload on public health or sanitary facilities which might increase the toll of truly serious sickness.

There is, however, one potential shortage which may have a serious effect on the problem of sickness absenteeism unless dealt with on a most intelligent and sober basis. I refer to the sharp decline in the supply of skilled medical service. This decline has resulted from increased Army needs in conflict with the expanding civilian demand which is developing as the incomes of substandard families are raised and as participation in disability, hospital, and surgical benefit plans is broadened.

Those borderline disabilities subject to surgical repair which can be delayed at the expense of discomfort only must not be subsidized *if* the medical profession is to stand the load during the next few years.

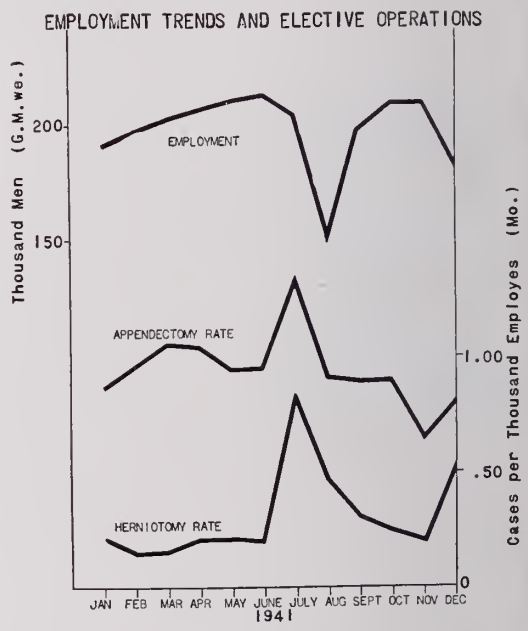


Chart 3

The next chart suggests strongly that a significant proportion of absenteeism is not the result of serious sickness. It is apparent that holidays and sporting seasons have taken their toll. Note that although the Fourth of July and Labor Day of this year were reflected in considerable lost time, the Michigan pheasant season showed much less of a peak than it did in 1941.

In our experience, there is little *gross* tendency for high absenteeism to be associated with longer hours within the range of plant averages, that is, from forty to fifty-five hours per week. This tends to substantiate the recent findings of the British

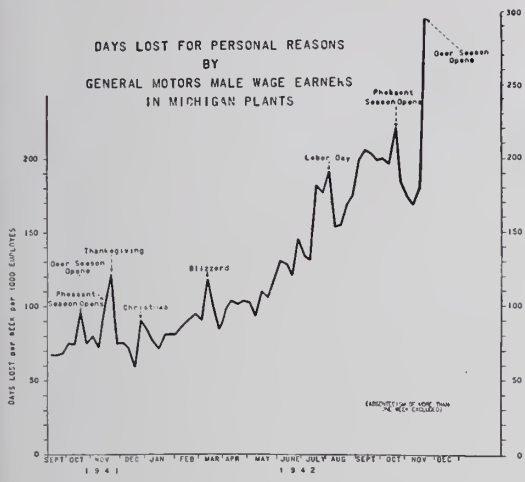


Chart 4

Medical Research Council in its "Hours of Work, Lost Time and Labor Wastage":

"The time lost due to sickness, injury and absence without permission, when undisturbed by other extraneous factors, varied with the weekly hours of work. It was usually reasonably low when the hours of work were less than 60 per week, but was higher, and in some cases excessive, when the hours were from 65 to 73 per week."

In this connection, it is instructive to compare the fifty-five to sixty hour conclusion of the British Research with the joint recommendation recently issued from Washington to the effect that "for war time production the 8-hour day and 48-hour week approximate the best working schedule for sustained efficiency." This "forty-eight and eight" conclusion is not confirmed by any analysis of actual experience, as far as I have been able to determine. It is in direct conflict with the detailed factual analyses recently published by the British. It does not agree with the indications of our records.

On the problem of optimum number of days of work per week, there is complete agreement. The British researches, the Washington officials, and our records agree that six days of work is the optimum but that seven days solid, week after week, usually makes trouble.

The next chart shows average time lost in a continuously running, automatic screw machine and assembly operation, where the men in one section were scheduled to work seven and a half hours for seven days and in the other section seven and a half hours on a six day swing shift. In this case, the personal days lost by the seven day men were about twice the lost time on the six day swing shift. In fact, the reduction in personal days lost offset about 40 per cent of the additional scheduled time off on the six day work week. Seven days every week is too much, even though daily hours are only seven and a half. The number of days of work per week are really more important than the hours. Ten hours for six days is frequently possible without serious loss in attendance or reduction in efficiency.

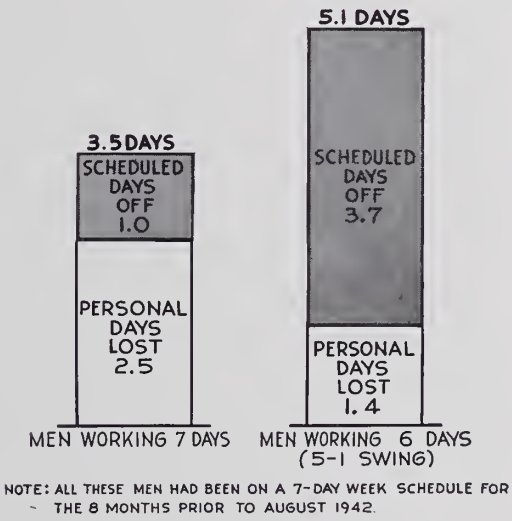


Chart 5

For example, one large munitions plant in this country today schedules about half of its working force for six ten and a half hour days and the other half for six eight hour days a week. The absenteeism is 5 per cent in the sixty-three hour operation compared with 4 per cent on the forty-eight hour week, despite the fact that the average service record of the sixty-three hour men is much below that of the forty-eight.

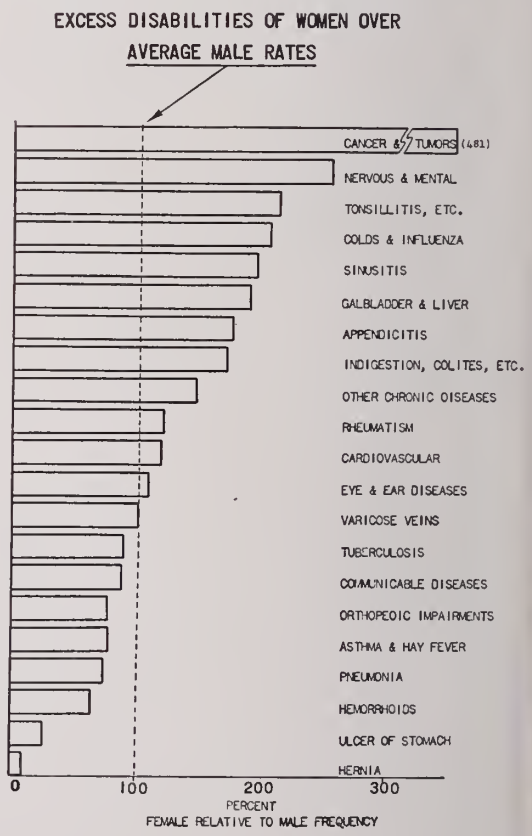
It is probable that a great majority of newly hired employes in our expanding

plants are now making a great deal more money per week than they ever did before. In fact, the average weekly wage of General Motors' male factory workers is about $55. This represents a 30 per cent increase over last year for the average long service employe. For persons hired recently who worked for other employers in the same locality a year ago, our current wages often represent a 100 per cent increase in income. For persons who were on WPA or relief a year ago or have moved in from rural areas, the increase in earnings is even greater.

In the lean days, most of these persons thought of increased incomes in terms of new durable goods or housing. Before the war, factory workers seldom saved against the abstract future. They saved to make the payments on a car or a washing machine. These are no longer available. Note the observation of Z. C. Pickinson: "even in Soviet Russia, and to some extent elsewhere, workers have occasionally reached a point where they had little desire for higher money earnings, not because they were overworked or all of their consuming wants were satisfied, but because so few goods were expected to be available for purchase with the extra earnings." Today, workers are saving to buy bonds and help win the war. Is the bond buying urge as strong an incentive to regular attendance as the necessity of meeting payments on a new car or washing machine used to be? When men miss time these days, they often request that their weekly war bond subscription be reduced. It was more difficult to brush off the collector from the finance company.

The previous discussion has been confined to time lost by men. From now on, in practically every factory, the proportion of women workers will increase substantially. In this connection, it is instructive to note that, although short-term absences of women have, in general, run about 30 per cent higher than for men, this is not true when we confine our observations to recent hires. The women added during the last few months seem to be distinctly more stable than do the new men. Startling at first, the logic clears when it is considered that a large proportion of the few men available for employment today are either habitual floaters, persons who have had a long record of submarginal employment, or immature persons taking a fling at industry before the draft. On the other hand, many women applying for employment are turning to war production from homemaking or steady work in retail trade or service industries. Among our best and steadiest workers are women with close friends or relatives in a theater of war.

Among employes with long service records, personal lost time and, particularly, sickness lasting over a week take a larger toll of the women than of the men. The next chart depicts the difference between male and female disability rates revealed by the United States Public Health Service survey. The diagnoses of great female excess probably reflect the incidence of new loads which will face the industrial physician.



SOURCE - U.S.P.H.S.-BUL. #260 - 1935-36
CHART INCLUDES ONLY MOST IMPORTANT DISABILITIES

Chart 6

The recent increase in marriages, combined with the necessity of drawing a large proportion of factory workers from former homemakers, makes the employment problems of the married woman increasingly important for industry. Should Army widows without children be considered married for statistical purposes?

Returning to the general problem of excessive nonsickness absenteeism, you ask, "What is the answer?" I don't know of a single, direct, guaranteed attack on the problem. It was obvious from the first chart that General Motors has not solved it. In both Britain and Germany, there is fine or imprisonment for persons frequently absent from work without adequate excuse. Such punitive measures seem impractical in this country. It is certainly to be hoped that they will not be needed.

Among the many suggestions which deal with the problem of unnecessary personal absences, I might list a few, some of which have been tried in General Motors plants with varying degrees of success.

Among the punitive plans, the first that comes to mind is the penalty layoff. It sounds absurd to lay a man off for being absent too frequently, but it is reported that it may really be effective. Although people like to take time off at their own convenience, they dislike losing a day of work as a penalty. In fact, one of the amusing things about the whole absenteeism problem is the way in which bargaining committees, every member of which has lost a day or more during the last month, will argue vigorously with the management about the undesirability of cutting the working time from seven to six days a week or of not working on some double time holiday. Hooky is fun, and the more time a man is scheduled to work, the more opportunity he has. Penalty layoffs can be an effective disciplinary measure if discipline is needed, and that is very seldom.

The second approach is to visit men with bad attendance records and those who are out more than a day or two in succession. Many personnel men find that these visits of simple inquiry about the worker's health are quite effective in reducing the lost time.

Several plants report that various sorts of rather low pressure follow-ups are effective. For example, telegrams to absent workers, a red notice in the clock rack telling the returning worker to report to his foreman for his card, and "Nazi money" in the pay envelope to cover personal lost time have all been tried.

Another procedure consists of a more or less onerous questionnaire to be filled out by persons returning after unexcused absences. This is designed partly as a penalty and partly in an attempt to get some information concerning the individual's situation and reasons for absence which might throw light on the general problem.

One suggestion is to keep a public record of the individual's absences in the hope that the group can bring pressure on the person who falls behind too much. "Missing from Action" lists have been suggested.

A basic approach to the problem is to increase emphasis of the attendance record in connection with any discussions of promotion, transfers, assignments of desirable work, settlements of grievances, or other points of issue between the employer and the employe. Individual attendance histories are essential in letting the employe realize that steady work is an important factor in getting ahead with the company.

Posters and other displays emphasizing the importance to the war production effort of regular attendance are frequently used. Award pins or certificates may be used in connection with good attendance records. This includes departmental contests as well as individual recognition. Day nurseries could be of great help to mothers with young children.

Another suggestion is to name individual products, when they are of sufficient size to be important, for persons who have good attendance production records.

The War Labor Board has recently made part of the wage increase awarded copper workers contingent upon the individual attendance and production record. Attendance bonuses are frequently discussed. Unless very carefully designed, they may work in reverse. For example, a man may get off to a bad start in the bonus period and be dis-

couraged by his inability to participate in the award.

It has been proposed that half-hearted workers be reported to their draft boards. Certainly, men with occupational deferments who are out too much should be reported.

An increase in the straight time hours of work under the Wages and Hours law extended to modify conflicting union agreements would forcefully put the individual on notice that the nation needed and expected more work per week of him. Such a change would clarify the recent public differences of Messrs. Roosevelt and Nelson on optimum hours of work. It would also reduce the inflationary gap of unspendable earnings.

If the income tax is to be collected from each pay in next spring's tax bill, the exact basis of levy may be important for absenteeism. A high tax above a minimum exempt weekly base could be expected to increase personal lost time. By contrast, a flat percentage levy on the total of each week's earnings should stimulate better attendance. Going even further, a flat, weekly, tax deduction based on the previous year's earnings (for example, the present tax law) would act as a powerful incentive to regular attendance.

John Stuart Mill early observed the basic importance of a cultivated desire for expensive living if sustained industrial effort is to be achieved. Mill pointed out that this importance of expensive tastes was particularly true in the tropics where nature made existence easy and saving pointless. A few generations later he would probably have included Social Security as a variety of tropical climate.

Taking this classic observation to heart, one employer of my acquaintance told me how he reduced excessive absenteeism during the last war by encouraging the sale of expensive furniture to his factory workers on extended time payments. A second employer's retort was that a much simpler procedure would be to invite a few professional gamblers to set up a shop near the plant.

You can see that irregular attendance is a complex phenomenon born of a great many factors. In its solution, management, workers, local authorities, merchants, owners of recreational establishments, wives and families can all cooperate.

Health in Industry*

By MR. WILLIAM D. JAMES**
Fort Atkinson

MR. W. D. JAMES

INDUSTRY is told that this is a war of production. Production is a race against time. *Time will not wait.* We cannot fight today's battles with what we will make tomorrow. Shortages in materials, labor, and man-hours in industry are today a distinct threat to our war effort. In this discussion we shall deal with *time,* and *man-hours.*

On what common ground do we in industry, and you, in the medical profession, stand in relation to the maintenance of production? We can agree, I am sure, it's the *loss of man-hours;* and that means, sabotage of man-hours resulting from illness and accidents.

Startling figures could be quoted to you of just what this sabotage represents when translated into terms of thousands of guns, planes, tanks, ships, and other war equipment and supplies. You have, no doubt, heard and read these figures.

Accidents occurring in or out of the shop are very real and tragic affairs. It may be interesting to note what statistics show on accidents. Eighty per cent of all accidents

* Presented before the Postgraduate Industrial Medical and Surgical Clinic of the State Medical Society of Wisconsin, Milwaukee, November, 1942.

** President of the James Manufacturing Company, Fort Atkinson, and President of the Wisconsin Manufacturers' Association.

are due to *man failure*. Eighteen per cent are due to failure of equipment or lack of proper safeguarding. Two per cent are purely accidents. Yes, accidents take their toll in human life, suffering, disability, and earning capacity. We have all worked for years to prevent this needless sacrifice.

Fortunately, we in Wisconsin have an Industrial Commission second to none cooperating with us, for which we are most grateful. It is a commission that has been tireless in its efforts to work with every interested company, group, and agency in accident prevention and rehabilitation of the injured worker.

We have had employer and employee cooperation that has achieved a remarkable and enviable record.

We want to pay tribute to the medical profession, the industrial nurses, and the health and safety workers for the fine cooperation we have had from them.

Yes, all of our efforts have been rewarded. That was yesterday! What of today?

Our good records of the past are threatened by new conditions the war has thrust upon us. Today industry is faced with new health problems, and the most serious accident problems in history. This is an experience I believe is happening in many places. Our company's plants have been converted in the last sixty days to doing 100 per cent war work, and most of the work is foreign to anything we have ever done before.

Much of our personnel is in uniform, and in the last forty-five days our factory payrolls have increased 52 per cent. It would be difficult to visualize what this means.

The change-over from peacetime production to entirely different products means, as it has with us, new machines, new processes, and the handling of new and sometimes little known materials.

The utilization of all labor necessitates the hiring of unskilled and, in many cases, physically handicapped workers, speed-up in production of men and machines, longer hours with attending fatigue; and difficulties in obtaining an adequate supervisory staff.

There is the mental and nervous strain placed on the workers, particularly the new ones who are over-anxious to prove their worth, especially if they are somewhat physically handicapped or have been out of work for some time.

Some of these factors will be remedied or somewhat minimized as time goes on and as industry hits its stride, but it will require super ingenuity, common sense, no small amount of good luck, and the wholehearted cooperation of everyone interested in "KEEPING 'EM WORKING" if we are going to save precious man-hours from being scrapped.

We are thankful to you of the medical profession for the wonderful progress you have made in treating illness and accident victims, in getting them back on the job as soon as possible with a minimum of suffering and disability. More and more we will need your guidance and skill in the proper placement of workers, rehabilitation of the disabled workers, and evaluation of work capacities of individuals whom we place on our payrolls as vacancies occur and as our war expansion continues.

We all know of the growth and wonderful progress of safety and accident prevention in the last twenty-five years. This is a job on which there must be no letting up.

Loss Due to Ill Health

We have now come to realize that many of us have neglected an even greater cause of time loss, that due to ill health. For a number of years, studies have been made here in Wisconsin and by several national agencies and private industrial establishments, and the information thus gathered has been brought to the attention of all of us, but too few of us have realized its importance and done something about it.

At the risk of stealing some thunder from the speaker that is to follow, may I stress that it is a known fact that *ordinary illness* accounts for several times more lost man-hours than result from occupational and non-occupational accidents combined. Workers must be kept well and on the job, for they are the only men we are going to have for some time to come, and production of war

materials is entirely dependent upon the man power available to industry today.

We are learning to take very good care of our automobiles. They go in for regular checkups, we shift the tires, etc. Listen to the advertising every night over the radio: "Bring your car in for a checkup. It's the only car you will have. Handle it with care. Drive thirty-five miles an hour and no more."

What do we do with the dairy cows on the farm? I have often wondered whether we realize that the dairy men of this country give their herds a health test once a year and more often twice. Yes, we insist upon it. You of the medical profession do too. That is what we think of the dairy cow.

How about our workers? We cannot limit their efforts. It's longer hours and more work under more trying conditions. Our fighting forces need *today* what was ordered *yesterday*.

Do all workers have regular physical examinations? Some do.

It has been established with reasonable accuracy that every year approximately nine days are lost from illness and accidents by each of the industrial workers of this country. The dollar value of this time is millions. As a result of this, it stands to reason that war production losses are extremely high. Industrial employers have a very real interest in this subject and are not at all satisfied with the situation.

A recent study of a group of our employees, representing what I believe is a very good cross section of the average business, included a foundry, a machine shop, a wood shop, a sheet metal shop, and a general fabricating plant. Seven hundred and seventy-four employees in this group last year lost 2,280 days due to illness.

What about accidents? Seven hundred and seventy-four employees lost only 340 days due to accidents. You will note this is 671 per cent greater than the days lost from accidents.

How many of these employees caused all of this illness? The answer is 132 employees out of 774.

Another finding is that sixty-four employees out of the 774 were responsible for 87 per cent of the days lost on account of illness.

If you are interested in knowing the number responsible for the 340 days lost because of accidents, you will be surprised when I tell you twenty-five—just twenty-five men!

We are very much distressed because of this record, and who wouldn't be. But now let's see what the national record is. A recent study made by the American College of Surgeons of the illness and accident records in a large number of industries (and it is about as good a record as I have ever seen) shows that days lost from illness were fifteen times greater than days lost from accidents. On a percentage basis, this is 1,500 per cent greater than the days lost from accidents. So our own record, and we are not saying it is good or that we are satisfied with it, was only about one-half as bad as the national record.

Health Programs

Many of our large organizations have instituted health programs. They have been productive of fine results, and they are to be congratulated. Much remains to be done to make this fine work applicable to our smaller industries employing from fifty to 500 people. Such development might conceivably be the fruit of the meetings we have had here today and tonight which have been among the finest it has been my pleasure to attend.

The production load imposed by the war upon American industry has been and is a challenge to both management and labor. Great accomplishments have been made within the period of a year. There still remains much to be done. Labor has and is cooperating. However, there is opportunity to assume far greater leadership in a matter of such vital consequence as health and accident prevention in industry. Likewise, there is a challenge to the medical profession, notwithstanding the fact that you have already responded nobly. Have all of us fully recognized the magnitude of our problems?

Of course, no one in industry is of the belief that all sickness can be prevented. There is reason to believe that, if we had placed as much importance and energy in this field of sickness prevention as we have all through the years in accident prevention, we would

now be in a position to reduce greatly the total of unnecessary lost time cases.

Whatever legal responsibility industry has in the case of accidents within our shops, we realize we also have a selfish and humanitarian obligation to the general health of our workers. Anything that is done to improve the welfare of our workers while they are within factory walls is bound to be reflected eventually in their homes and in the communities in which they live.

"In the good old days" we knew what our health hazards were and how to combat them, and we were able to do a rather good job. That is largely changed now.

Gone are many of the known raw materials; new ones have taken their places, introducing new or unknown hazards and in some cases far more serious ones. Due to the scarcity of many raw materials, industry has been forced to accept substitutions, and frequently without time to learn fully the dangers.

Then too, equipment for adequate control measures to prevent disease is becoming more and more difficult to obtain. How would you like to equip a hospital today?

We are confronted with many headaches, not alone in preventing the known occupational diseases, but also in anticipating some new and unexpected ones. All of us in industry and science must be on the alert for this potential danger.

The influx of large numbers of war workers in some of our heavily industrialized areas, with poor housing facilities, adds other health problems. An outbreak of infectious and contagious diseases could seriously hamper our war production. Among the more serious ones, we must keep in mind such illnesses as influenza, typhoid fever, small pox, scarlet fever, diphtheria, and tuberculosis. In some Wisconsin areas large-scale vaccination programs have been instituted. The time to prevent serious epidemics is before they begin. Physicians, industrial nurses, health and safety workers will have to exercise every precaution to prevent the spread of any contagious or infectious disease that may appear. The facilities of local and state health agencies for the prevention and control of epidemics should be utilized to the full.

In industry we have tried to provide good places in which to work. We need the man power to accomplish the task and responsibility given us to produce and turn out the tools to win the fight, and we cannot afford to treat lightly any circumstances that may weaken that ability. Industry is willing and wants to do a good job in the conservation of man power.

In carrying out these tremendous responsibilities we need *your leadership, tutorship, and wholehearted cooperation,* and then *we* will make history in the solution of these problems.

For the last year the Wisconsin Manufacturers' Association has been working with the Wisconsin Council of Safety in developing a health and accident program which we will be able to announce shortly, and with it we are going to announce many contests. This program contemplates the full cooperation of management, labor, the medical profession, the industrial nurses, and health and safety workers. In this plan we realize we have a selling job to do. Just as we have been preaching and teaching accident prevention, we must likewise become health conscious and do those things that will contribute to a health-building program.

We are grateful to you of the medical profession for this opportunity to have a better understanding of our needs, objectives, and mutual problems, so we can all work together on this home front to protect our man power and thus provide ample supplies for our boys out on the fighting fronts of the world.

Just by keeping well we can help win this war.

LET'S "KEEP 'EM WORKING!"

Do you wish to be listed on the Society's Workmen's Compensation Panel? If so, be sure to return your application at once. *Act now!*

In Memory of John Baird, M. D. 1860-1942*

By WILLIAM E. GROUND, M. D.
Superior

DR. BAIRD is dead. What hard, barren words! To say we are sorry seems empty chanting as applied to the life and work of a truly great physician. We profoundly mourn his loss, and loss it is for us, for no one can take his place in the lives and hearts of the people he has served so faithfully and well for more than half a century. It will be hard to become adjusted to his absence, for our community without a Dr. Baird is almost irreconcilable.

As a man and a citizen, friend and neighbor, he was all that a man should be, and as this phase of his life has been dealt with, I will confine my very inadequate remarks to Dr. Baird as a physician.

Professionally, I have known Dr. Baird for more than fifty years, coming in contact with him almost daily, as our work frequently overlapped. In this category I could with equal propriety place Dr. P. G. McGill, as with him too I was equally associated for five decades. It is difficult for me to think of one without the other, as our professional lives were so thoroughly interwoven during the half century just past.

Dr. Baird was a man of rare medical judgment, and he thought out his cases to an accurate diagnosis. He was a clinicial doctor in contradistinction to a mechanical doctor. While he employed laboratory and other aids to diagnosis when needed, he did not rely on these as main factors. Like many another great clinician, he formed a mental picture of the patient and his disease as a whole that was extremely accurate, and upon this he based his therapeutics. He must have realized that it was just as important to find out what kind of a patient the disease had as it was to know what kind of a disease the patient had. In naming the diagnosis, he seemed to realize that no one term would cover it all, as most frequently the patient had more than one disease. With his clinical sense, he saw disease in its broadest phase, and he could not have been a specialist because he could not have limited himself to the one organ. The truly great physician is the general practitioner, or clinician as I prefer to call him. He knows much about much, instead of much about little. He alone sees the man and his disease as a whole and not just piecemeal. Not just a womb, a prostate, or a nostril, but man as a human being, specialized from the whole biologic world and possessing not only a physical but a psychic and spiritual being as well. Individuality of thought and action is basic in medicine, and taking this away disperses whatever special talents the individual may have had. This is the great objection to state, social, federal or regimented medicine. You may regiment a railroad, but you cannot regiment medicine and get the best results. To overcivilize and underhumanize the practice of medicine is in my opinion a great mistake.

Early Days of Medicine in Superior

Coming to Superior when it was but a hamlet on the banks of Lake Superior, when living was anything but easy, Dr. Baird began the practice of medicine in the hardest way. Professional duties took him through ice and snow and cold and mud, through brush and heavily wooded forests. That was the setting in those days. Although the Euclid Hotel was subsequently built, everybody did not live in and around the Euclid, but the patients were scattered far and wide over Douglas County. This when transportation was primarily ham and calf, the horse and the bicycle, with frequent trips made into the wilderness on the logging train and tote team to the lumber camps to treat the sick and injured. Facilities for getting about town, especially between the east and west end, were meager and dilatory. For be it remembered that while we did not have mountains to climb, we had mud in plenty to wade,

* Presented before the Douglas County Medical Society and the Duluth–Superior Academy of Medicine.

bogging down both man and beast, for there were no paved streets. The main means of getting back and forth between the east and west ends was a horse car, and I mean a horse car. The car was not much bigger than a large dry goods box, drawn by one horse along a course of rusted iron called a track, and which looked more like a huge grapevine strung along the ground. On the front of the car was an open space called a platform. On this space stood the "gedda-up man," and he was plainly discernable in the summer time, but when the rigors of winter made their appearance, and that was pretty early and lasted a long time, the driver was then transformed into a huge bear-like object swathed in a bearskin coat with gloves and cap to match. The cap had a couple of peep holes in the front so the driver could see to keep the horse between the rails. West Superior was getting to be quite a town about now, and the demands for passage between the two towns were frequent and often meager. People were often heard to remark: "I want to go to the west end the worst way. How can I get there?" They were told to take the first horse car that came along, that being the worst way then known. This was supposed to be very funny and mirth provoking.

When Dr. P. G. McGill and I came here in June, 1891, Dr. Baird had been here three years. He had founded the Douglas County Medical Society. The first meeting we attended was in Dr. Baird's office. Among those present, I recall Dr. McGill, John Specht, and Dr. C. V. Beebe (the father of our present Dr. Beebe), Shean, Beck, Conklin and Dr. Conkey. We met in one anothers' offices in those days, and mighty pleasant and informative meetings they were too. On special occasions, such as annual meetings, we would meet in the Euclid or the West Superior Hotel. In a pinch, we might assemble in the back room of a saloon, and there was a plentiful supply to pick from in those days. While Dr. Baird neither smoked nor drank, he was complacent about it and went along with the crowd.

Intubation of the Larynx

During the winter of 1890–91, I took some postgraduate work and refresher courses in New York. Among them was intubation of the larynx for obstruction due to diphtheria and was under the inventor Joseph O'Dwyer and his assistant Dillon Brown. The facilities for practical work in intubation were practically unlimited, as diphtheria was rampant in those days. The tenements of New York were full of it, and to these places we would go to intubate the living babes and to the morgue of Bellvue Hospital to practice on the dead.

The winter of 1891–92 saw much and very fatal diphtheria here in Superior, many families losing one-fourth to one-half of their children. We intubated a great many cases in the next three or four years until diphtheria antitoxin came into use. Then tubing the larynx for diphtheritic stenosis was rarely called for. This is one of the most dramatic examples of medical discovery in the golden age of medicine.

Dr. Baird was one of the first to recognize the value of intubation, and it was over the suffocating babes that I learned to appreciate the great humanitarian that he was. During the intubation, the child had to be held upright like it was hanging from the ceiling, usually in the lap of a parent or friend or neighbor. The procedure was often most distressing, as the babes were almost black from suffocation. Usually Dr. Baird would do the holding. Once I remember the victim coughed a piece of membrane in Dr. Baird's face, and he contracted diphtheria and did not get out again for nearly a month.

Subsequently we came together often, helping each other in difficult and complicated cases of which there were plenty. Difficult deliveries and major surgery were done in the houses on the kitchen tables or a table improvised with boards, or maybe we would have to take a door off its hinges and lay it on a couple of sawhorses. These houses were often mere shacks and hovels constructed of black tar paper, rough boards and the like. There were buildings called hospitals, but the facilities were limited and they were poorly equipped and were usually

full of infection and pus cases, typhoid fever and pneumonia. Although tough going, we found that we had better results in the homes. Here we did much major surgery, such as complicated labor cases, appendicitis, gallstones, intestinal obstruction, perforated gastric ulcer, ruptured tubal pregnancy, hysterectomy for cancer and ovariotomy, besides innumerable fractures, simple and compound. We did not hesitate to do an amputation if occasion required.

Both Dr. Baird and Dr. McGill received their educations in Canada and were adepts in the use of chloroform, the anesthetic we almost invariably used in our obstetrics and surgery. I do not recall any specially distressing experiences, and it was used under the most adverse circumstances.

Most Prolific Age of Medicine

We lived and worked through the most prolific age of medicine. When we first entered medical school, bacteriology was just being conceived, and the carbolic acid spray was still in use in the surgical clinics. If you stood in with the professor, you might be permitted to pump the handsprayer into the air over the operating field. That was back in the later 70's and early 80's. It was not until the later 80's that we began to wash our hands before as well as after the operation. Even in the 90's, butchers' aprons were worn, sleeves were rolled up, and whiskers were long enough to trail in the operating field. No caps, masks, or gloves were used. The whiskers died hard, and as they were considered a sign of virility, the doctors like every one else were reluctant to give them up. Surgically they were clearly a menace, and before mowing them down completely, they were placed in a bag which the nurse would more or less deftly tie around the surgeon's head. The walrus mustache held on for a little longer, then vanished almost completely, except now and then we see one in the vestigial or terminal stage.

Dr. Baird was also one of the founders and charter members of this Interurban Academy of Medicine organized just forty-eight years ago this month. The first meeting was held in Superior. Of the original twenty-five charter members, only four remain. Drs. S. H. Boyer and C. F. McComb in Duluth and Drs. Orchard and Ground in Superior.

REGISTRY OF TROPICAL DISEASES

Doctor Harry Beckman, Marquette University School of Medicine, is desirous of establishing a registry of all cases of tropical and exotic diseases which the war is certain to bring to the state in increasing numbers —such entities as malaria, Weil's disease, filariasis, relapsing fever, giardiasis, Strongyloides dysentery, fluke and rare worm infestations, histoplasmosis, endemic flea-borne typhus, etc. He will be very grateful to any physician reporting such cases to him, will place pertinent details in the Archives of the American Society of Tropical Medicine, and ultimately will publish, with due credit to the reporting physicians, a compilation of the cases for the State of Wisconsin.

THE NATION AT WAR

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Army and Navy Plans For Students*

Many efforts have been made recently to explain to the public the new Army and Navy plans for students, but we just couldn't decipher the thing. Others apparently came to no conclusion either since the Journal has received many requests from Students and other interested persons for a clarification of these plans for maintaining students in college. We went to the source—the Army and the Navy. Our results follow:

Army

Eligible: Enlisted men 18–22 who have completed basic training.

Assignment: Students have no choice of college.

Courses: All technical.

Training Period: Varied according to courses.

Enlisted Reserves:

(1) *Medical students in the enlisted reserves will be called to active duty at the end of the first semester which begins in 1943, then detailed to their present studies under contracts which the war department will make with the respective colleges. Medical students with commissions in the Medical Administrative Corps will be allowed to resign these commissions for the purpose of re-enlisting as privates in the enlisted reserves, for assignment under the college training program to continue their studies. Pre-Medical students will continue in an inactive status until the end of the next semester, at which time they will be inducted into the army, and "selected" students assigned to continue their studies under the College Training Program.*

(2) Seniors in the ROTC will be called to active duty at the end of the next semester and sent to branch schools to study for commissions.

(3) Juniors in the Reserve taking approved engineering courses will be called to active duty after next semester and given basic military training; "selected" men will then go back to their engineering studies.

(4) All other enlisted Reserves will be called at the end of the current semester for basic training, then will be eligible for the special training in colleges.

Future: After specialized training, soldiers will be selected for

(1) Officer Candidate School.

(2) Technical Non-commissioned Officer's Rank.

(3) "Very Advanced" technical training, in "exceptional cases."

(4) Technical work outside the Army, in "very exceptional cases."

(5) Return to the troops.

Navy

Eligible: High-school graduates or the equivalent, 17–19 at enlistment; or men already enlisted and over 17 and under 23. All must have 18/20 vision, and must possess officer-like qualities.

Assignment:

(1) If possible, trainees will be sent to colleges of their choice.

(2) Trainees can express preference for the Navy, Marines, or Coast Guard.

(3) Any trainee may transfer to Aviation at any time.

Courses: Two sixteen-week semesters: embracing a preliminary curriculum for all, stressing fundamental college work in math, science, English, history, engineering drawing, and physical training. All students will also be given general instruction in the organization of the Navy, Marines and Coast Guard.

Training Period: Required curricula will vary in length, depending on the training requirements. Curricula will be stipulated by the Navy and will be continuous.

Reserves:

(1) Enlistment in the V-1 training program for those who are 17 will be halted on March 15. Those now in V-1, V-5, and V-7 will be called to active duty and will be allowed time to complete the college courses stipulated by the Navy, if they maintain satisfactory standings.

(2) *Those in Navy approved medical, Dental, and Theological Training* (on accelerated programs) *will continue as apprentice seamen, and will continue their studies. Those holding HV-(P)* (inactive) *commissions will be allowed to resign them, at a date to be announced in the near future, for the purpose of re-enlisting as apprentice seamen, for assignment to the college training program to continue their studies. The Navy plans to provide clothing, quarters, and subsistence, the men to receive the pay of apprentice seamen ($50.00*

* An editorial appearing in The Journal of the Louisiana State University School of Medicine, January, 1943.

monthly) while on active duty. These men will be recommissioned upon the completion of their prescribed professional education. Men now classified under HV-(P) need not resign their commissions unless they desire to do so. (3) Naval ROTC units will continue, with additional members chosen from trainees in the college training program, after the first two semesters.

Future:

(1) After additional specialized training in the Navy, Marines or Coast Guard, all those who pass will be commissioned as reserve officers.

(2) All those who flunk will get "other active duty."

The date of call to active duty for men now enlisted in the Navy's Class V-1, V-5, and V-7 reserve classes has not yet been announced; it will, however, be at some date after the completion of the present semester.

The Navy's plan provides for a continuous, necessary supply of officer candidates in the various special fields required by the Navy, Marine Corps, and Coast Guard, and it will permit selection of the country's best qualified young men on a broad democratic basis, without regard to their financial status, to meet the future officer requirements of the service.

These plans as listed above are not quite complete, nor have the finer details been worked out. As further information is received The Journal will endeavor to give it to you promptly.

COMMITTEE ON WAR PARTICIPATION

In July of 1942, following the June meeting of the American Medical Association in Atlantic City, the Council of the State Medical Society reorganized its previously designated M-Day Committee to meet the increasing complexities involved in the responsibilities of the profession to the war effort.

By appointment of the chairman of the Council, the Committee is composed of the president, president-elect, chairman of the Council, state consultant of the Procurement and Assignment Service, and the secretary of the Society, with the Committee as a whole composed of three subcommittees—that on the Procurement and Assignment Service, on Civilian Defense, and on Replacements.

The Subcommittee on Procurement and Assignment Service serves in an advisory capacity in matters concerning general policy, while the Committee on Replacements is concerned with fulfilling community or institutional health needs as they may occur. The Subcommittee on Civilian Defense is composed of those physicians having official positions in the Civilian Defense activities of the state and acts in a liaison capacity with the Wisconsin Council of Defense, particularly with reference to programs involving emergency medical service and general health problems. Personnel of the three subcommittees is:

Subcommittee on Procurement and Assignment Service

E. J. Carey, Milwaukee, chairman
H. M. Coon, Madison
J. W. Prentice, Ashland
F. X. Pomainville, Wisconsin Rapids
P. R. Minahan, Green Bay

Subcommittee on Replacements

R. W. Blumenthal, Milwaukee, chairman
S. D. Beebe, Sparta
E. C. Cary, Reedsville
H. A. Sincock, Superior
A. A. Cantwell, Shawano

Subcommittee on Civilian Defense

J. S. Supernaw, Madison, chairman
R. W. Blumenthal, Milwaukee
V. E. Ekblad, Superior
T. C. Hemmingsen, Racine
A. G. Koehler, Oshkosh
F. G. Anderson, Eau Claire
C. N. Neupert, Madison
J. W. Lambert, Antigo

MILITARY NOTES

J. W. LAMBERT

Captain Joseph W. Lambert, formerly of Antigo, is now stationed at Fitzsimons General Hospital, Denver, Colorado, where he is serving in the capacity of instructor in surgery. He received his commission in the Medical Corps of the Army last October.

Mrs. Lambert and the two children expect to join Captain Lambert about the middle of March.

Captain Lambert specialized in the practice of internal medicine and obstetrics in Antigo for eighteen years. He was graduated from Northwestern University Medical School in 1923 and interned at Cook County Hospital in Chicago. He served as inspector for the American College of Surgeons in 1924. A First Lieutenant in the Med-

ical Reserve Corps, with assignment to the fiftieth surgical hospital, from 1929 to 1939, Captain Lambert has also a record of fourteen years of active service as Designated Examiner, U. S. Veterans Bureau. During World War I he enlisted in the Medical Reserve Corps and was discharged following the armistice.

Formerly president of the resident staff of Cook County Hospital, a position he held in 1922, Captain Lambert served as a member of the Committee on Medical Education and Hospitals of the American Medical Association from 1931 to 1933.

At the time of entering service, Captain Lambert was Councilor from the Thirteenth District of the State Medical Society of Wisconsin, an office he had held for six years. He was chairman of the Subcommittee on Civilian Defense of the Committee on War Participation and was Chief of Emergency Medical Service in his district.

Captain Lambert was the first Langlade County physician to enter the armed forces during the present war.

LIEUTENANT HAROLD BAXTER, NEENAH, COMMENDED FOR OUTSTANDING CONDUCT

From: The Commander South Pacific Area and South Pacific Force.

To: Lieutenant Harold L. Baxter, (Medical Corps), U. S. Naval Reserve.

Via: The Commanding Officer, U. S. S. ----------.

Subject: Commendation.

1. During the night of October 11–12, 1942, your ship was engaged in action against the Japanese Naval Forces off Cape Esperance, Guadalcanal, Solomon Islands.

2. As Junior Medical Officer of your ship you showed complete disregard for your own safety during and after the action. You were unceasing in your efforts to aid the wounded and your work was a decided contribution in the saving of the lives of the wounded.

3. The Commander South Pacific Area and South Pacific Force wishes to express his commendation and considers that your conduct was in keeping with the highest traditions of the Naval Service.

W. F. Halsey.

Headed by Major Stanley W. Hollenbeck, a Milwaukee physician, the staff of the first portable hospital unit to go into service in the southwest Pacific area recently returned to their base somewhere in New Guinea after two and one-half months on the New Guinea front. Major Hollenbeck said that his outfit and others which followed provided proof under fire of the value of these new portable hospitals and that care had been given to badly wounded men who certainly would have died without prompt treatment. He said, "We performed operations by flashlight and under very difficult conditions and learned to get along without the instruments and facilities which we once considered indispensable. We also learned to keep going. Half my staff contracted malaria. We couldn't spare them so they kept right on the job while taking malarial treatment. All pulled out of it in good shape."

—△—

Dr. Howard F. Pagel, Ladysmith, has been promoted to major and regimental surgeon at his station in New Guinea. Major Pagel joined the reserves the fall he was graduated from the Marquette University School of Medicine, in 1938. He was called into the Army in February, 1941.

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At its meeting at the Athletic Club early in February, the Lions' Club of Milwaukee heard Dr. William T. Casper, navy lieutenant now detached from service and returned to Whitefish Bay, give an eye witness account of the landing of an American combat transport in Africa.

Dr. Casper spent weeks helping set up a miniature hospital in the transport. Although Dr. Casper's transport was expected to take care of hundreds of wounded as a result of the landing, it had to handle only a small number. He was loud in praise of blood plasma and sulfanilamide as two great factors in saving lives.

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Lieutenant Mark M. Temkin, Beaver Dam, now with a hospital unit in Australia, spoke from Australia over an international radio hookup in explaining details of a delicate brain operation at which he assisted. Speaking with him was the patient whose life he saved, Corporal C. M. Hoehn, who wrote to Mrs. Tempkin after returning to the States. Corporal Hoehn reported that Dr. Temkin "was in the best of health and spirits, very busy, and liked by all the boys and nurses."

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The newly completed thirty-two building base hospital at Peterson Field, Colorado Springs, Colorado, is superintended by a West Allis doctor, Major I. J. Sarfatty. Major Sarfatty was graduated from the University of Wisconsin in 1931 and from the Marquette University School of Medicine in 1934.

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Dr. J. J. Horwitz, attending gynecologist and obstetrician at Mount Sinai Hospital, Milwaukee, and a diplomate of the American Board of Gynecol-

ogy and Obstetrics, has been commissioned a major in the Army Medical Corps. He left Milwaukee for Carlisle Barracks, Pennsylvania, where he was to be assigned to the Army and Navy Hospital at Hot Springs, Arkansas.

Dr. Horwitz spent two years in the far east, during which time he organized and directed a military hospital in North China.

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According to word received by his mother, Lieutenant Colonel Harold Nebel, Milwaukee physician who is in the Army Medical Corps at Camp Young, California, has recently been promoted to that rank.

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Lieutenant Jack L. Kinsey, formerly of Milwaukee, reports that he has been transferred to duty at the U. S. Naval Training Station at Great Lakes, Illinois.

—△—

Lieutenant Gerhard D. Straus, formerly of Milwaukee, writes that he is well satisfied with army life in that he is actively practising his specialty, Ear, Nose, and Throat, at the Station Hospital, Chanute Field, Illinois.

—△—

Lieutenant Albert F. Rogers, Milwaukee, is with Major Parker C. Hardin, Charleston, Illinois, one of the most bombed American army doctors. Despite many interruptions, Major Hardin and his officers have treated many wounded.

"We have seen almost no infection, even though men lie in the jungle all night or longer," Major Hardin recently told in a front line hospital somewhere in New Guinea. "In this base we clean wounds sometimes without adequate sterile water or sterile goods. We can't and don't do much surgery. We pack wounds with sulfanilamide, put on heavy pressure dressings and then don't dress wounds again unless there is a particular need.

"Sometimes we give sulfanilamide by mouth. In one case a boy who had a hand blown off was with us nine days before we could get him out, but no infection developed principally because of sulfanilamide.

"The gas gangrene which caused so much trouble in France (during the first war) hasn't been seen. I believe the reason for this is that the land here is uncontaminated by animals or humans as it was in France."

Because the Army recognized the value of the sulfa drugs before war was declared, it put in large stocks. Not only do all medical soldiers know how to apply the drug, but line soldiers themselves carry sulfanilamide tablets to take immediately if they are wounded. As a result, wounds remain uninfected when soldiers are brought into advanced base hospitals and still remain uninfected when finally the soldiers are evacuated to hospitals in the rear.

Major Hardin declared that much credit was given to sulfanilamide, which he termed "truly a miracle drug."

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Dr. E. C. Cary, Reedsville, writes from Portland, Oregon, as follows: "Enroute to Camp White, Oregon, for a visit with our son, Captain John F. Cary. Beautiful here at Portland—all sunshine and no snow. A two weeks' vacation." Captain Cary formerly practiced at Sheboygan.

MILITARY NEWS URGENTLY REQUESTED

The State Medical Society is endeavoring to keep its record of men in service as up-to-date as possible. The accuracy of this information can be maintained only by the wholehearted cooperation of everyone to whom any such information comes.

We do not want to overlook the name of any Wisconsin physician who is in the armed forces of his country.

Therefore, when a physician enters service, the Society would appreciate receiving information as to his rank and assignment from him or from his family or friends.

IMPORTANT NOTICE

The state consultant in Wisconsin for the Procurement and Assignment Service for Physicians asks that Wisconsin physicians who have applied for service with one of the branches of the armed forces and have been rejected on physical grounds forward at once two copies of the notice of rejection to the state office of the Procurement and Assignment Service, 2750 North Teutonia Avenue, Milwaukee. This is to enable that office to clarify the status of Wisconsin physicians and to avoid recertification of men as available for service who already have been rejected.

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« « « EDITORIALS » » »

"Of Cabbages—and Kings—"

AN ILLUSTRATION in the November issue of *Fortune* magazine comes to mind, particularly in these recent days following the decision of the United States Supreme Court. *Fortune* pictures the dilemma of the young family man as he scans the scare headlines of the press—"Heads of Families Deferred," "Married Men to be Drafted Soon," ad infinitum.

There must be in the minds of many of us a similar state of confusion respecting the status of medicine. No analogy other than the one above need be drawn, but doubtless there is a pessimistic note through it all as we reach the erudite conclusion that "things will never be the same again."

Well, we might answer, when were they ? The history of our country, and the history of our profession, have never been static, but always changing. However, so long as we can hold fast to the underlying logic that change is not necessarily synonymous with progress, both we and our people need not dread the "desert behind us" nor "the darkness before."

Of course, we shall face changes, and debate changes, and with some we shall be in complete accord, and in others possess a doubt that challenges proof. But that is the burden of a democracy and its opportunity to demonstrate its worth. Certainly, no single mind, nor single philosophy, can open the pages of history yet to be written. That power is for none of us to claim.

But we can stop to choose the path, and with logic we can generally choose the right path. Logic is dependent on knowledge, knowledge of what one is seeking and why he is seeking it, and that implies a knowledge of the true facts of the present, and their interrelationship one to another.

Let us take stock, for a moment, of just what we are, and more important, why. Here in the United States of America, blessed with a people determined to preserve all that is good in the free principles of democracy, blessed with a country generally sufficient unto itself, yet a good neighbor, we find a people healthy, well clothed, strong and vigorous. We find them so because of their own capacity to absorb good principles of living and to teach them to others. We boast of our health achievements, we seek their improvement, and as no other country we pile statistical proof upon statistical proof, and comparative chart by comparative chart, to sustain our conclusion that here in the United States can be found the nearest thing to Utopia, now, and in the future.

As those claims relate to public health—a term very nearly synonymous with the medical profession—we assume a justifiable pride, and yet still want more. There is where the profession comes into the picture as that in itself becomes a social or economic trend, or by whatever term one may choose to characterize it. The Supreme Court in its ultimate wisdom has seen fit to declare certain negative policies governing the manner in which the profession may offer the public its own convictions in these all-important fields. So be it—and in that decision the medical profession must and willingly shall abide.

We seek no special privileges. All privileges in the final analysis are those only of the people, theirs to claim, to use, to delegate, to nourish, and always to cherish. And that which the people of this country have cherished perhaps the longest has been that of acquiring knowledge. A frequent quotation that for so long a time articulated the voice of medicine in this state was that of Dante: "Give light that the people may see the way."

Isn't that our responsibility? And we need not permit confusion of that responsibility with the opinions of those who would erect artificial and needlessly circumscribed boundaries of thought and speech. Such a course is not inevitable—certainly not desirable.

Committed always to that which assures the maximum standard of health for the maximum number of people, there is neither cause to flinch, nor halt, nor pause in uncertainty. We hold fast to those principles by which this country has climbed to the rung where it is today, determined ever that we shall move ahead again as in the long days of the past.

We shall and must "give light that the people may see the way."

Conservation of Local Medical Care

OUR contemporary publications in other states are a constant source of stimulation. In the *Journal of the Iowa State Medical Society*, there recently appeared an editorial relating to the need for the conservation of local medical care, so that there may be an adequate distribution of medical care for all. The Iowa Journal believes that some of these matters should be brought before the public, and says:

". . . One of the most important is that people should be extremely careful to avoid disturbing the night's rest of the exhausted physician for anything but definite necessities. An unnecessary phone call after midnight or at five or six o'clock in the morning seriously cuts into the busy doctor's six or seven hours of sleep, which he sorely needs if he is to be at his peak of efficiency for the day's heavy load. To get him out of bed at night for an unnecessary house call is even worse. True, there are unavoidable and unforeseeable night emergencies to which doctors will gladly respond, as they always have, but it is a safe prediction that well over half of the night disturbances to which physicians are subjected could wait over the few hours until morning or could have been attended to the day before. Some of the coronary and other arteries which have been on the job for over half a century are bound to give way if the strain becomes too great. The public should conserve these arteries, and one way of doing it is to refrain from disturbing the doctor's sleeping hours unless an urgent situation develops.

"Another way in which the public can help is to adopt the attitude of sacrificing their convenience to the convenience of the doctor instead of vice versa. Many people who work or who have something else to do during the day wait until evening or Sunday to call the doctor. Ambulatory patients should make the effort to see their doctor during his office hours. They should remember that a few hours of rest after a hard day's work are essential to the doctor if his physical well-being is to be safeguarded.

"Then, too, people could save a great deal of the doctor's time if they would be more careful about preventing injuries, accidental poisonings, and communicable illnesses. A neighborhood youngster of ours had the right idea when he called his gang together and told them they had to be more careful. 'There's a shortage of doctors now and we can't be taking up their time by getting hurt.' Parents could well follow this unusual lad's example. In industry a national committee is spending thousands of dollars in an effort to reduce man-hours of work lost through accidents in order to maintain production at full capacity. Why not a similar campaign on the home front so that the doctor will not need to use his limited time for sewing up minor wounds and fixing broken bones which a little more foresight could have prevented.

"There is another important thing every family should do. All poisonous substances, such as insect poison, rat poison, medicines, kerosene, gasoline, cleaning fluids, lye, and many others, should be kept in places where childish hands cannot possibly get at them. Hardly a week goes by that the doctor whose practice includes children is not called upon several times to treat some child who has swallowed a potential poison. Kerosene is one of the worst offenders and if aspirated into the lung sets up a

chemical pneumonia which may require weeks of medical and hospital care. In our own experience within the last six days, one child drank deodorant solution, another ate ant poison, a third swallowed ten laxative tablets and a fourth drank a bleaching fluid.

"Still another way in which the general public could reduce its demands for medical service is to really go after the problem of spread of communicable diseases. Proper precautions are customarily followed in common diseases such as measles, whooping cough, mumps, scarlet fever and the like, but all these put together are but a mere pittance compared to the ravages wrought by infections of the respiratory tract. The development of a 'cold', or influenza, in one member of a family should become a challenge to the other members of the family to avoid getting it. A great deal more care could be exercised in excluding from school children with coughs and colds. When persons with communicable infections of this type mingle freely with non-infected persons, the inevitable result is the development of some illness sufficiently severe to require medical attention and hospitalization. It would be ridiculous, of course, to expect that all illnesses of this sort could be prevented, but a real effort in this direction on the part of the public would certainly help.

"This is a time, too, when preventive inoculations should be tremendously increased. People who permit themselves or their children to acquire diseases for which there are reliable immunizing agents are as unpatriotic as those who use tires and gasoline for unnecessary purposes. No physician in Iowa should have to be called upon to treat a case of diphtheria or smallpox throughout the duration of the war.

"These are some of the things—there are others—which the people at home should understand clearly if they would conserve their limited supply of doctors and conserve the time of their doctors for most efficient use. A heavy responsibility rests upon the shoulders of the physicians whose unsung and prosaic rôle during the present crisis calls upon them to put forth double or even quadruple efforts without the distinguishing glory of military insignia. They fully comprehend the trust placed in them by the men in military service, some of whom are serving valiantly in distant lands, to look after their loved ones at home. That trust is not misplaced. The people at home will be taken care of, but it will help much during the trying days ahead to have a sympathetic and cooperative citizenry."

WHY AN EDITORIAL PAGE?

It seems that ordinarily the editorial space of any publication has as its primary effort the stimulation of objective thinking—and all too often develops into some unequivocal directive, in which the incentive for independent reaction becomes a "dare" to contradict.

THIS COLUMN, HOWEVER,

Is intended primarily to act in the character of a "refresher" course—continually reminding the physicians of the State Medical Society of the activities of their organization, its work, its responsibilities, its plans. . .

SO OCCASIONALLY,

We mention such activities as the annual meeting, or the now famous "Spring Clinics." For "fillers" in other portions of *The Journal* are printed current medical-economic news items, or other material.

THUS YOUR JOURNAL

Becomes an ever-increasing item of importance to your professional work. Through its columns you are presented with vital scientific information, material relating to the Nation at War, News of the Neighbors, and other pertinent information.

YOUR JOURNAL ADVERTISERS

Are of real importance to every physician in Wisconsin. Through their utilization of *The Journal* you are assured of their reputability and of the standards of their products. Give *The Journal* a credit line when you deal with them—their cooperation helps sustain *The Journal.*

ABOVE ALL

Recall that the profession has said for years that there is no divergence between the interests of public health and the interests of the medical profession. They are truly one. Therein lies your pride and great sense of responsibility in being a medical man.

When the need arises, contact your State Medical Society. As you develop reactions to its policies, convey those thoughts to your office. The Society cannot be a thing apart *from* its members, for it is *of* its members. Epitomized in its being are the work, the pride and the joy of the doctors of Wisconsin. Share in it—it is not alone your privilege but your responsibility.

. . . . THE PRESIDENT'S PAGE . . . .

"Irresistible"

"FEW persons realize that what is called 'a great social trend' is no more than the propaganda put out by the opponents of a free society to confuse, disorganize and disarm the defenders of that society. *There is no such thing as an irresistible social trend. It only becomes so when everyone ceases to resist it.*"

There is real food for thought in the above statement made by Professor Harley L. Lutz of Princeton University during his address before the War Congress of American Industry in New York City last December. It expresses ingeniously and pointedly a critical analysis of the publicity that lies behind many of the programs laid before the American public today. All too often we have heard statements to the effect that the medical profession should "get on the band wagon," as though there were some irresistible movement in one direction which could neither be controlled nor deviated from its dangerous course.

This writer has said on many occasions that he supported the beliefs of those who feel that the medical profession should do all in its power to educate the public, as well as itself, to the inevitable consequences of certain suggested plans or schemes which would place under state control the delivery of medical care. It is not the writer's purpose here to review the arguments pro or con, nor to "point with pride" to those sound phases of state medicine which are today a part of our social structure, and are so largely at the insistence of the medical profession. While these elements of our position are an old story to the medical man, they are not necessarily an old story to the lay public.

We shall continue to reiterate our opinion that a highly technical personal service is not a skill which, like a commodity, can be packaged and sold. Its quality in the United States can be measured largely by its accomplishments in a free society. Dilution by artificial limitations will neither protect our present standards of medical care nor promote the public welfare.

Those who believe that medical care could be made more generally available through a system of socialization do not realize that *cheapened* care would be substituted for *cheaper* care. The State Medical Society of Wisconsin steadfastly has held that the insurance principle may be applied to the delivery of medical care where the benefits are measurable in cash rather than in service. This is true because cash is measurable by the average individual.

There is no irresistible social trend to the development of a widespread form of state medicine. But there is an objective common to us all to increase the benefits of medicine and their availability to all. In that objective medicine is devoting its best, and to that objective medicine pledges its utmost support.

F E Butler

Postgraduate Industrial Medical and Surgical Clinic Scheduled for Madison May 5 and Appleton May 6

REALIZING that every man hour saved for agricultural and industrial employes is a direct contribution to the war effort, the Council on Scientific Work, in cooperation with the Society's Committee on Industrial Health and the Industrial Hygiene Unit of the State Board of Health, has arranged a second Postgraduate Industrial Medical and Surgical Clinic. The meeting will be held at the Loraine Hotel in Madison on Wednesday, May 5, and at the Conway Hotel, Appleton, May 6. Dr. Erwin Schmidt, Chairman of the Council on Scientific Work, has arranged the program.

The attention of the entire nation is focused on the urgent need of keeping every farmer and industrial worker on the job. Every worker and every hour counts. Again the slogan, "Keep 'Em Working," has been selected as the theme for this further postgraduate effort of the Society. The need for skilled farm workers is so critical that many recognized authorities have declared that, unless some relief of this shortage is advanced at once, we may face a serious food shortage during the ensuing year. It is essential, therefore, that time loss experienced by farmers as a result of injury and sickness be kept at the lowest possible minimum. Returning the skilled farmer or farm employe to work as soon as possible, compatible with sound medical practice, is the responsibility of the physicians of Wisconsin.

The imperativeness of keeping factory and office personnel at work, performing their particular part of an integrated production plan, is known to all. The absence of one worker not only leaves his own job undone, but also affects the production effort of others who are dependent on his part of the process. In the production line, each person must do his part on time and well, or the efforts of all the others are nullified. Wisconsin physicians must do their part to "Keep 'Em Working."

We must and we will keep our home-front workers at their jobs just as the armed forces keep our fighting men at their posts. To accomplish this, we must keep abreast of the newer developments in the treatment and care of occupational injuries and diseases. We must anticipate the new medical and health problems that have been brought to Wisconsin for the first time as a result of new industries and new crops. An example of this is the anticipation that in Wisconsin we will have for the first time an appreciable number of cases of "Hemp Fever," or mill fever, which is caused by a virus that develops in the processing of hemp. Wisconsin leads the nation in the acreage of hemp. This next year the acreage of hemp will be increased many times.

Through an alertness to the problems and by the application of the newer developments in medical science, we will be able to discharge our patriotic obligation. To this end, the second Postgraduate Industrial Medical and Surgical Clinic has been arranged to refresh the minds of physicians on already known facts and to bring them the benefit of the special studies and skills of those who have won recognition for their work.

In addition to the scientific program which has been arranged for physicians, a special program has been arranged for employers, nurses, personnel directors and others interested in industrial health problems. Several round-table luncheons have been scheduled for them as well as complete afternoon and evening programs. The afternoon session will be conducted simultaneously with the afternoon scientific sessions. The Society, through its individual members, extends to all employers, industrial nurses, personnel directors and others a cordial invitation to attend this meeting on industrial health which has been arranged for them.

Check the program—circle the date on your calendar—plan now to attend.

PROGRAM

Postgraduate Industrial Medical and Surgical Clinic
Wednesday, May 5, Madison

A. M.

8:30– 9:00 Registration
8:30– 8:45 Dermatosis in Industry
8:45– 9:00 Fracture Motion Picture Film
9:00– 9:10 Introduction of Program
9:10– 9:30 Late Development in the Treatment of Burns
9:30– 9:50 Sulfonamides and the Treatment of Wounds
9:50–10:10 Clinical Concept of Shock and Its Treatment
10:10–10:30 Virus Pneumonia in the Army and Its Relation to Industry
10:30–10:45 Recess
10:45–11:05 Pros and Cons for the Routine Immunization of the Industrial Workers Against Tetanus
11:05–11:25 Why Do Fractures Head the List of the Causes of Disabilities?
11:25–11:45 How Can Fracture Disabilities be Reduced?

Round Tables:
1. Dermatoses in Industry
2. Treatment of Burns
3. Respiratory Infections
4. Common Industrial Fractures
5. War Gases
6. Industrial Hand Infections and Accidents
7. The Placement Examination
8. Public Round-Table Luncheon
9. Public Round-Table Luncheon

P. M.

2:00– 2:20 Gas Used in Warfare
2:20– 2:40 Diagnosis and Treatment of Gas Casualties
2:40– 3:00 New Medical Problems War Industry Has Brought to Wisconsin
3:00– 3:20 Common Colds and War Efficiency
3:20– 3:35 Recess
3:35– 3:55 Health Problems Provoked by Employment of Women in Industry
3:55– 4:15 Placement Examinations in Industry
4:15– 4:35 The Problem of Employing the Physically Handicapped and Aged
4:35– 4:55 Accidents Peculiar to Agricultural Industry
4:55– 5:30 Scientific Motion Picture

Special Program For Employers, Nurses and Personnel Directors

P. M.

2:00– 2:20 The Nurse in Industry
2:20– 2:40 Health Education of Employes: Facilities and Procedures
2:40– 3:00 Manufacturing Association
3:00– 3:20 Value of Midmorning and Midafternoon Lunches
3:20– 3:35 Recess
3:35– 3:55 Optimum Hours of Work—Fatigue in Relation to Production
3:55– 4:15 Wisconsin Workmen's Compensation Act
4:15– 4:35 Employe Viewpoint
4:35– 4:55 Actual Demonstration of Placement Physician Examination

6:30 Dinner

7:30 The Safeguarding of Industrial Health by Industry and Medicine
7:50 As Industry Sees the Problem
8:10 Optimum Hours of Work
Why Do Employes Stay at Home, and What Can Be Done About It?

Application Blanks for Listing on the Society's 1943 Workmen's Compensation Panels Mailed Early in March

PREPARATIONS have been begun by the Society on the Workmen's Compensation Panels for distribution to over 50,000 Wisconsin employers. During the first week in March, every member of the Society received an application for panel listing to be filled out in the event he desired to be listed on the panel for his county.

Each year since the Society has distributed the panels to employers subject to the Workmen's Compensation Act, there has been a broader application of the Open Panel Agreement. Employes are given the opportunity to select the physician to attend them from the panels posted in their plants, offices, branches, factories, and stores.

Distributed with the panels will be a letter from the Industrial Commission, as well as a letter from the Society. Included in the Commission's letter of 1942 was the following statement to employers concerning the granting of choice of physician to the injured employe:

> "When injury has occurred, a real choice should be given to the employe of his attending physician. No attempt should be made to persuade or coerce him into accepting the services of a certain physician. Attention should be called to the panel, and the employe should be requested to make his selection without suggestion or comment on the part of the employer, except as requested by the employe."

The Wisconsin statutes provide that employers subject to the Workmen's Compensation Act must afford injured employes a "reasonable choice" in the selection of physicians to attend them when injured during the course of their employment or to treat diseases which have been determined subject to the Workmen's Compensation Act. The Wisconsin statutes in earlier years provided for a specified number of physicians that must be included on an employer's panel. This provision was removed at a recent session of the legislature and gave to the Industrial Commission discretionary power as to the number that is to be "considered reasonable" for the individual community.

Members of the Society, in accordance with the specific provision in the Open Panel Agreement, are automatically eligible for listing on the panel by signifying that they will abide by the provisions of the Open Panel Agreement and the application for panel listing.

Members of the Society who wish to be listed on the panel, but who have not returned their application blanks, are urged to do so at once.

Additional application blanks may be obtained by writing to the secretary's office.

Minutes of the Council; Milwaukee, January 9-10, 1943

1. Call to Order

The Council was called to order at 7:30 p. m., Saturday, January 9, in the library of the University Club, Milwaukee.

2. Roll Call

The following were present, constituting a quorum: Councilors Gavin, Arveson, Blumenthal, Jegi, Pippin, Pechous, Hough, O'Leary, Clark, Christofferson, Eberbach, Fitzgerald and Heidner; Past-President Gundersen; Speaker of the House Fidler; Vice-speaker Minahan; Treasurer Sisk; President-Elect Kurten; Dr. C. A. Dawson, chairman, Committee on Public Policy; Eben J. Carey, president, The Medical Society of Milwaukee County; C. N. Neupert, state health officer; George B. Larson, assistant secretary, State Medical Society of Wisconsin; James O. Kelley, executive secretary, The Medical Society of Milwaukee County; legal counsel R. B. Murphy. Due to the death of his mother, Secretary Crownhart was absent.

3. Approval of Minutes of September, 1942, Meeting

Upon motion by Blumenthal–Jegi, the minutes of the September, 1942, meeting of the Council were approved as published in the November issue of *The Wisconsin Medical Journal.*

4. Election of a Chairman of the Council for 1943

Upon motion by Councilor Christofferson and variously seconded (Councilor Arveson presiding) Dr. Gavin was nominated to succeed himself as chairman of the Council for 1943. No further nominations were made. Dr. Arveson declared the nominations closed, and the assistant secretary was instructed to cast the unanimous ballot of the Council for Dr. Gavin.

5. Election of a Secretary of the Society and of the Council for 1943

Upon motion by Jegi–Arveson, Mr. Crownhart was nominated to succeed himself as secretary, and upon motion by O'Leary–Fitzgerald nominations were declared closed and the assistant secretary was instructed to cast the unanimous ballot of the Council for Mr. Crownhart.

6. Election of a Treasurer of the Society and of the Council for 1943

Upon motion by Arveson–Fitzgerald, Dr. Sisk was nominated to succeed himself as treasurer. Nominations were declared closed and the assistant secretary was instructed to cast the unanimous ballot of the Council for Dr. Sisk.

7. Councilor District Reports

The chairman stated that in accordance with the by-laws and the order of business mailed prior to the meeting, Councilors would be called upon for reports of their respective districts. The report of his district preceded those of other Councilors.

Sixth District

Dr. Gavin stated that one of the most valuable procedures in his district was regular meetings of officers and delegates of the several county medical societies comprising his district. A minimum of two meetings of all presidents and secretaries of county medical societies as well as delegates from the district were held each year, and frequently special meetings are held. The purpose of these meetings is to apprise officers of county medical societies and delegates of important actions taken by the Council, as well as important state and national medical trends.

On the basis of a survey made of county societies in the Sixth Councilor District, each county medical society had held at least ten meetings during 1942, and attendance at all meetings was "remarkably good."

One district meeting was held during 1942 with a total attendance of 300 to 400.

Dr. Gavin concluded by summarizing the membership status of the four county medical societies in his district, as well as offering a discussion of the number of members in service and a relationship of the number of physicians remaining at home to the population.

First District

The Councilor for the first district, Dr. A. G. Hough, was called upon for his report. He stated that inasmuch as the period which had elapsed since his election as Councilor of the first district to the present meeting of the Council was so short, a comprehensive report of conditions in the district could not be given. He stated that during the coming year at least one district meeting would be held, probably in Waukesha County. He believes that the question of military service continues to be one of the chief problems in his district.

Second District

Councilor Pechous reported to the Council on the relationship of the number of physicians in service to the population of the counties in his district and stated that there were no communities experiencing an acute shortage of physicians at the present time. Frequent meetings had been held, and during the past year, in Kenosha County, the question of various plans of practice occasioned extensive discussion.

Third District

One district meeting was held during 1942, according to the report made by Councilor Clark.

Large numbers of physicians had left his district. This was accentuated by departure of the special unit from the University of Wisconsin Medical School. A number of physicians had been found by Procurement and Assignment to be essential, due to the fact that the Badger Ordnance Works was located between Baraboo and Sauk City with a marked influx of population and the need for retaining teaching personnel at the University of Wisconsin Medical School.

Civilian defense preparations in his district were emphasized by Councilor Clark, pointing out that the location of the powder plant at the Badger Ordnance Works, the large number of men located at the Truax Air School, as well as several large war industries, necessitated unusual precaution and preparation. This has been organized under the supervision of Dr. J. S. Supernaw, Madison.

The appendicitis survey in Rock County and in the district was conducted during the past year and reported on at the Annual Meeting, both by means of an exhibit and a scientific paper.

Fourth District

The importance and effectiveness of the Fourth Councilor District meetings were emphasized by Councilor Pippin. The success of these meetings was attributed in large measure to the efficiency of the district Society secretary, Dr. Mina Glasier. Excellent scientific programs were developed at the meetings and were looked forward to by the physicians in the district.

At the annual district meeting, public health problems were discussed with legislators and other public officials in the district. Elected public officers had indicated their appreciation for this opportunity to be apprised of pending health problems.

Fifth District

Among the problems discussed by Councilor Heidner were the application of the Open Panel Agreement and efforts being made by a county society in his district to effect still further the choice of physician (from the panels supplied by the Society) by injured employes. He also reported on studies being made by a second county medical society in his district for a prepaid medical care plan embracing surgical and obstetrical benefit coverage by employed groups. The county medical society is working with the Committee on Medical Economics and Voluntary Sickness Insurance of the State Society in the formulation of the plan.

Seventh District

Councilor Jegi stated that the district meeting, usually held at La Crosse, is well attended. This city represents the only metropolitan area in the district and has proven most successful for the holding of the district meeting. The La Crosse County Medical Society holds regular monthly meetings which are attended by physicians residing in neighboring counties.

Councilor Jegi called attention to the near approach to a physician shortage in one or two of his counties due to entry of men in the service and others leaving the community for other locations. This had not occasioned an acute problem to date,

but unless attention is directed to prevent further depletion of physicians in the territory, an acute problem would develop.

The health problems occasioned by the marked influx of civilian population in the Camp McCoy district was discussed by Councilor Jegi. He pointed out that conditions were being met by local physicians and public health officials.

Eighth District

Councilor Krahn was absent due to illness. Consequently no report was presented to the Council from his district. The Council was advised that Dr. Krahn was a hospital patient at Madison.

Ninth District

Four scientific district meetings were held each year in the Ninth Councilor District, according to the report presented by Councilor Christofferson. In addition, Dr. Christofferson held a meeting of the officers of the county medical societies located in his district to discuss public health matters and important actions taken by the Council, as well as other current medical problems in the district.

Tenth District

Emphasis was placed by Councilor Arveson upon the need in the Tenth District for acquainting physicians with current public health problems. Throughout the past year, stress had been placed upon a program to acquaint public officials with the public health objectives of the physicians in Wisconsin.

Eleventh District

Councilor O'Leary reported that the district meeting of the Society is held during the summer of each year. Meetings are held alternately in Superior, Ashland and Bayfield. Monthly meetings are held by the county medical societies, and further scientific advantage is obtained by the meeting of the Interurban Academy of Medicine comprised of Duluth and Superior physicians.

Twelfth District

Councilors Blumenthal, Eberbach and Fitzgerald reported that approximately 950 members were located in their district and that the councilor area was that of Milwaukee County, and consequently what might be termed a district meeting is held monthly. The Council was advised that there were no particular problems in the district. Postgraduate courses are held regularly and a journal published by the Medical Society of Milwaukee County. Dr. Blumenthal stated that there was no shortage of physicians in the county.

Thirteenth District

Councilor J. W. Lambert, who represents the Thirteenth District, is now in active military service, and consequently, no report for that district was received.

8. Report of the Treasurer

Dr. Ira R. Sisk, treasurer, presented the following report for the year 1942:

REPORT OF DR. IRA R. SISK, TREASURER

For the Year Ended December 31, 1942

Cash in bank, January 1, 1942			$ 9,690.49
Receipts			
Membership dues		$61,270.67	
Annual meeting revenues		6,971.85	
Graduate center fees		2,421.25	
Interest on investments		1,000.16	
Proceeds from the sale of securities		7,226.30	
Sale of printed materials, booklets, etc.		96.55	
Miscellaneous receipts (refunds of expense)		494.87	
Wisconsin Medical Journal's share of Social Security taxes		37.70	
Monthly installments on insurance policy proceeds		1,188.36	
Total receipts			80,707.71
Total to be accounted for			$90,398.20
Disbursements			
Constitutional Officers and Committees			
President's travel	$ 500.00		
Council and committees	2,892.37		
Books and periodicals	258.69		
Delegates to A. M. A.	359.24		
Auxiliary	100.00		
Secretary's salary	5,970.00		
Secretary's travel	1,355.58		
Group total		$11,435.88	
Staff			
Salaries of staff	$11,755.92		
Assistant secretary's normal travel	479.63		
Group total		$12,235.55	
Administrative Expenses			
Accounting and insurance	$ 665.39		
Social security taxes	363.55		
Rent	1,800.00		
Telephone and telegraph	1,698.49		
Supplies and light	913.96		
Postage and printing	2,148.44		
Fixtures and upkeep	230.53		
Miscellaneous	709.72		
Group total		$ 8,530.08	
Membership, Special Services			
Legal	$ 1,477.54		
Special bulletins to members	98.64		
Blue Book issue	600.00		
Annual meeting	9,513.98		
Graduate centers	3,267.67		
Wisconsin Medical Journal	2,100.00		
Industrial health	3,360.95		
Group total		$20,418.78	
Public Health, Special Services			
Hygeia	$ 262.50		
Press (Health and public instruction)	1,139.88		
Lay publications	92.00		
Bulletins to members	22.77		
Services, general counsel	1,500.00		
Voluntary sickness insurance trials	148.25		
Group total		$ 3,165.40	
Total budgetary disbursements		$55,785.69	
Nonbudgetary Disbursements			
Membership dues refunded	$ 1,568.55		
Exhibit space refunded	22.50		
Investment securities purchased	10,071.75		
Total nonbudgetary disbursements		$11,662.80	
Total disbursements			$67,448.49
Cash in bank, December 31, 1942			$22,949.71

Securities Owned December 31, 1942

Description	Interest Rate	Maturity	Face Value
Pacific Telephone and Telegraph Company	3¼	12- 1-66	$2,000.00
Milwaukee Gas Light Company	4½	3- 1-67	2,000.00
Dayton Power and Light Company	3	1- 1-70	3,000.00
Wisconsin Power and Light Company	3¼	8- 1-71	3,000.00
United States Treasury	3¼	4-15-46	2,000.00
United States Treasury	2½	9-15-72	3,000.00
United States Savings Defense, Series G	2½	6- 1-53	2,000.00
Pennsylvania Power and Light Company	3½	8- 1-69	2,000.00
Southern California Edison Company, Ltd.	3	9- 1-65	2,000.00
Wisconsin Gas and Electric Company	3½	4- 1-66	1,000.00
United States Savings Defense, Series G	2½	6- 1-54	6,000.00
Milwaukee Gas Light Company	4½	3- 1-67	1,000.00
United States War Savings, Series G	2½	9- 1-54	3,000.00
Securities owned December 31, 1942			$32,000.00

Summary of Society's Funds December 31, 1942

Cash on deposit:	
Treasurer's account at the First National Bank of Madison	$22,949.71
Secretary's petty cash account at the American Exchange Bank of Madison	300.00
Secretary's dues account at the American Exchange Bank of Madison	102.00
Securities owned, face value	32,000.00
Proceeds of insurance policy on deposit with the Aetna Life Insurance Company	8,453.20
Total Society's funds, December 31, 1942	$63 804.91

Councilors inquired of the treasurer as to the leeway exercised in purchasing investments. Dr. Sisk advised the Council that he had in the past limited the investments to those which would qualify for trust funds in Wisconsin. He stated that he further limited the investment purchases during wartime to government bonds.

Upon motion by Jegi–Heidner, the report of the treasurer was accepted.

9. Introduction of State Health Officer

C. N. Neupert, the newly appointed State Health Officer, stated that the public health objectives of the State Board of Health and those of the State Medical Society, during his experience as Assistant State Health Officer, had been identical.

The Council was advised by Dr. Neupert that the state was reasonably free of communicable diseases during the past year except in specific localities. Even with the marked influx of population to such areas as that surrounding the Badger Ordnance Works, the Truax Air Force School at Madison, and at military camps McCoy and Williams, no marked increase of communicable diseases had developed in these communities. Epidemics which had been expected due to wartime traveling population did not materialize, but he indicated that there was still an opportunity for widespread epidemics of influenza and pneumonia. An all-time low in smallpox incidence occurred in 1942 with only forty-one cases as compared to 151 the previous year. Prior years recorded an even higher incidence. Warning was advanced by Dr. Neupert that if the ratio of physicians to population is not carefully watched, we would experience great difficulty in controlling epidemics in certain areas should they develop.

Councilor Arveson expressed the sincere conviction that the physicians throughout the state, and particularly the Council, would profit by a periodic report from the State Board of Health as to our exact state of health and disease trends in the state. The Council expressed its wish that physicians in the state be apprised of impending health problems and the activities of the State Board of Health through the medium of *The Wisconsin Medical Journal.*

Upon motion by Fitzgerald–Pechous, the following resolution was unanimously adopted by the Council: The State of Wisconsin is highly honored by the election of Dr. Neupert as State Health Officer, and the medical profession in Wisconsin offers him its wholehearted cooperation and support.

10. Resolution in Honor of Dr. C. A. Harper

Based upon the suggestion advanced by Councilors Pippin and Kurten, a motion was made by Kurten–Clark that a memorial be prepared for presentation to Dr. Harper and that the chairman of the Council appoint a committee to prepare a resolution for consideration of the Council at the morning session. Motion was unanimously carried.

Chairman Gavin appointed Drs. Kurten, Pippin and Gundersen to prepare a resolution for the Sunday morning meeting.

11. Interim Report of the Secretary

The interim report of the secretary, which follows, was adopted upon motion by Kurten–Arveson:

Membership

Since this report is being prepared during the holiday season, final membership figures cannot be given. But the situation can be clearly enough shown to provide the Council with basic information relative to general conditions.

Membership in 1940 totalled 2,550; in 1941, the total was 2,579; and at the close of 1942 the total is 2,623. Membership may be summarized as follows, with comparison drawn to the 1941 totals:

	1941	1942
1. Fully paid members	2,389	2,146
2. Partially paid members	12	17
3. Members in service paying no dues	38	105
4. Members in service paying pro rata dues	57	227
5. Members in service who have not yet reported date of induction	21	66
6. Life, honorary and affiliate members	62	62
Totals	2,579	2,623

At the close of 1941, the secretary reported fifty-seven delinquents; this year the total is fifty-one. Total deaths among members in 1942 were forty-seven, and many of these were among those whose dues were currently paid.

Membership in 1943

As of the date of this report, there are nearly 400 members of the Society in service, and numerous others are preparing to enter shortly after the first

of the year. On the basis of information coming to your secretary's attention, it appears that 300 physicians now in active practice are expected to enter service from Wisconsin during the course of 1943. All of these will be taken directly from active practice, and, in addition, virtually all interns will be taken directly upon licensure, with the state also furnishing a large percentage of its residents and graduates in training.

These figures, it may be added, bear out the figures presented before the House of Delegates at the September meeting, when it was estimated that full dues paying membership at the close of 1943 would probably total about 1,850, perhaps as low as 1,750. Councilors will wish to note that of the full dues paying membership at the close of 1942, some are now deceased. Second, there will be, until war ceases, fewer physicians to replace members lost by death or removal. Third, that the procurement objective for 1943 is based upon *active* practitioners, this meaning, in the secretary's opinion, that virtually all will come from the membership roll of the Society.

County Secretaries

The report of the secretary during past years has constantly noted with deep appreciation the vital and completely goodhearted cooperation of county secretaries. Your secretary can do nothing more than to acknowledge again their key service within their respective societies, for without them it would indeed be chaos. Repeatedly during the past year they have been called upon for information with respect to members in service, for assistance in locating physicians formerly resident within their districts, and for a multitude of other items too numerous to mention. They have responded promptly and in detail. The councilors are again urged to convey to these physicians the real appreciation of both the Council and the secretary's office, and to remind them that in special recognition of their valuable contributions to the organization of medicine, the 1942 House of Delegates directed that a special program of particular interest to them be prepared to precede the first session of the House, and that they be invited to attend this function as well as the first and subsequent sessions of the House as its special guests in 1943.

The Wisconsin Medical Journal

Various problems concerning *The Journal* have been outlined in connection with the budget. However, it seems apropos here to note the increasing value of *The Journal* as the house organ of medicine in Wisconsin, as well as an instrumentality for the publication of material of recognized scientific value. The secretary's office is constantly receiving comment from those in service as to the eagerness with which each copy of *The Journal* is received—a not infrequent observation being, "It is read from cover to cover not only by myself but by many a doctor from other states." This alone seems to justify the efforts made to distribute *The Journal* to all our members, no matter where they may be.

During this past year a considerable amount of material of an economic character has been carried in its columns. In this manner there was distributed the card, "In Time of War," as well as the special June supplement, "Health and Food," some 7,000 extra copies of this having been distributed throughout the state. It is planned that material of like value will be carried in *The Journal* during 1943, and that constantly it may become of increasing value to the members of the Society through the addition of further sections of a character similar to that of "The Nation at War."

The Blue Book issue has become a Wisconsin tradition and continues to receive wide comment. The December issue has been devoted to this material in the past, but this year the January issue has been selected, both because of the difficulty in obtaining late information on certain recently enacted federal laws and regulations, as well as the desirability of issuing the Blue Book in the year for which it is intended to be of use.

The secretary would be remiss in his responsibility if he did not note here the valuable assistance of Dr. Karl Doege, of Marshfield, the medical editor. Did he not give so freely of his time in assuring publication of truly valuable scientific contributions, and were he not so prompt and cooperative, it would be impossible to issue a monthly journal so widely recognized for its value.

A tentative profit and loss statement for the year ending December 31, 1942, follows:

WISCONSIN MEDICAL JOURNAL

TENTATIVE INCOME AND PROFIT AND LOSS STATEMENT

For the Year Ended December 31, 1942

Income		
Advertising*		$10,054.19
Subscriptions		122.18
Total publication income		$10,176.37
Expenses		
Printing	$8,572.82	
Salaries	1,884.19	
Cuts	725.13	
Mailing**	387.55	
Rent	540.00	
Miscellaneous expense	49.00	
Supplies	32.01	
Accounting service	180.00	
Editorial expense	125.00	
Discounts allowed	16.93	
Depreciation	12.42	
Old age benefit tax	19.10	
Bad debts	5.00	
Total publication expenses		12,549.15
Publication (loss)		$(2,372.78)
Less: State Medical Society appropriation		2,100.00
Net loss for the year		$(272.78)

Tentative Balance Sheet December 31, 1942

Assets		
American Exchange Bank		$ 1,508.79
Accounts receivable—advertisers*		738.17
Postage deposit**		36.39
Office equipment (depreciated value)		64.59
Total assets		$ 2,347.94
Liabilities and Surplus		
Current liabilities		None
Surplus, January 1, 1942	$2,620.72	
Less: Net loss as above	272.78	
Surplus December 31, 1942		2,347.94
Total liabilities and surplus		$ 2,347.94

* Subject to correction when final figures are available.

** December Post Office bill not yet submitted.

The Reserve Account

The accounting procedures of the Society were established at a time when its membership was considerably smaller and its dues income less. It still remains a thoroughly adequate system for the purposes of the Society, yet some changes are now indicated as a result of a greater amount of paper work required under various government regulations, as well as from the steadily increasing complexity of the Society's affairs.

The accountant for the Society is now engaged in perfecting the new accounting procedures, which are largely of a mechanical character. However, the Council will be interested in the fact that a separate reserve account will be carried on the books, which

will show at all times the principal invested, to which will be credited income from those investments, as well as the monthly proceeds from the insurance policy carried on the life of the late secretary. In this manner, your secretary as well as the treasurer will be better able to visualize the situation as it pertains to the reserve of the Society, and income from sources within that account will always be clearly separated from the general income of the Society.

The cash on hand at the end of the year will total approximately $22,000, as will be noted from the treasurer's report. This cash balance represents in considerable amount various carry-over appropriations, and thus cannot be placed in the reserve of the Society. However, it appears that of the total, $4,000 can be transferred to the reserve, and both the treasurer and the secretary assume the permission of the Council to do so. This means, in substance, that this account now totals $45,000.

1943

The determination of the budget for the ensuing year is the prerogative of the Council at its annual meeting. The material following as a concrete suggestion of the secretary's office is predicated upon the estimate furnished the House of Delegates at the annual meeting in 1942, when dues were increased from the 1942 amount of $25 to $29 for 1943.

With a conservative estimate of 1,800 full dues paying membership by the end of 1943, as well as taking into account the fact that those entering service during that year will doubtless be distributed fairly evenly throughout the year, it seems fairly safe to assume a dues income of approximately $56,000 during that year. Yet, in anticipation of required adjustments either in 1943 or 1944, due to lessened income, your office has postponed issuance of a new panel until midsummer of 1943, as well as placing the cost of the forthcoming Blue Book issue of *The Journal* into 1943, so that budgetary adjustments may be made if necessitated by later developments.

It is appreciated that 1943 holds much that is critical to all of us as a nation dedicated to preservation of our form of self government. But none of us can contemplate the holocaust abroad without appreciation of the surging currents beneath. How they may grow, or in what direction they may carry us on a wave of social changes, can only be dimly visualized. Certain it is that in the days ahead the medical profession must be as completely prepared to lead as it has in the past. To that effort your office pledges its complete cooperation.

Respectfully submitted,
C. H. Crownhart.

The increased burden and pressure upon the central office were discussed by President-elect Kurten and Councilors Clark and Fitzgerald. Chairman Gavin appointed the following as a special committee of the Council to consider what action might be taken by the Council to relieve in some measure the pressure that had been placed upon the secretary's office and to report to the Council the following morning: Councilors Arveson and Heidner, President-elect Kurten and Treasurer Sisk.

12. Sympathy to Secretary

The Council requested that a telegram and token of sympathy be sent to Mr. Crownhart in memory of his mother whose death immediately preceded the meeting of the Council and prevented his attendance.

SUNDAY, JANUARY 10, 1943

13. Report of the Committee on Public Policy

Dr. C. A. Dawson, chairman of the Committee on Public Policy, reported to the Council the activities of his committee on questions of public health and legislation. The committee, after extensive consideration, felt that the legislative activities of the committee for the Society should be limited to the sponsorship of the following measures: (1) bill to provide for annual re-registration of physicians; (2) to provide increases in salary for the state health officer and deputy state health officers; (3) a bill to provide for the payment of medical services in acute emergencies under the relief laws.

In clarification of the latter bill, Dr. Dawson stated that present statutes provide for the payment to hospitals for service rendered if notice is filed with relief officials within twenty-four to forty-eight hours. Under the proposed measure, services of the physician would be included, but question had been raised as to whether this law covered medical bills as well.

Upon motion by Jegi–Christofferson, the report of the Committee on Public Policy was unanimously adopted.

Other public health questions discussed by the Council included (1) observation for patients suspected of being mentally ill, (2) inadequate physical examination of employes in industry and (3) itinerant practitioners.

14. Budget for 1943

The budget which appears below was explained in detail to the Councilors item by item, and there was extensive discussion by the Councilors on each item. The budget as approved by the Council is as follows:

I. *Constitutional Officers and Committees*

1. *President.*—Initially authorized by the House of Delegates in 1935, this has been an annual appropriation to the president to assist in travel, long distance telephone calls, and other expenses incident to the office _____ $ 500

2. *Council and committees.*—The activities of the Society have required several meetings of the Council each year, with its sixteen voting members and four ex-officio members. While councilors are entitled to traveling expense, actually only those who travel some distance file statements. This appropriation also covers meetings of the various committees of the Society, $250 for stationery and postage expense of the councilors and committee members (such as annual meeting committee chairmen) who are called upon to do a considerable amount of correspondence.

   During 1942 this account has felt a considerably greater impact as a result of the war activities of the Society. An increase is warranted _____ 3,250

3. *Books and periodicals.*—This account has carried the cost of supplying councilors and committee members with publications believed of real importance. In recent years, $250 has been provided, and this has proved barely sufficient ..... $ 250

4. *Delegates to the American Medical Association.*—Wisconsin has three A. M. A. delegates. Formerly, a delegate was reimbursed for railway and pullman fare alone, having half of his time free to attend scientific sessions. The work of the A. M. A. delegate assembly has so increased as to keep it in substantially continuous session. In 1943 the scientific sessions will be temporarily dropped, but sessions of the House of Delegates will be held in Chicago. The appropriation is sufficient to provide each delegate, in accordance with earlier established policy, with substantially full reimbursement for actual expenses 175

5. *Auxiliary.*—The Auxiliary receives but 25 cents from its members. Its importance in public health work warrants continuance of the limited amount of $100 to assist the four principal state officers in defraying their postage and stenographic expense 100

6. *Secretary, salary* 7,000
On motion by Arveson–Clark, the salary of the secretary was placed at $7,000.

7. *Secretary, travel.*—The secretary has been reimbursed for actual expense necessitated by official travel. Committee meetings outside of Madison, the A. M. A. sessions and conferences, and similar functions are necessarily attended.

The necessary travel for 1943 is difficult to estimate due to war conditions and uncertain needs. No decrease is indicated 1,275

Total—Constitutional officers and committees $12,550

II. *Staff*

8. *Assistant secretary, salary.*—In 1942, the salary for this position was increased from $3,300 to $3,750 3,750

9. *Assistant secretary, travel.*—This enables the assistant secretary to attend certain committee meetings and other functions 400

10. *Secretarial Staff.*—The Society is confronted with a problem in respect to the securing of a capable and loyal staff entirely similar to that encountered by every group during this period. In the past year, the office has lost three of its employes who had served the Society long periods. One left to accept a more remunerative position offered her in the Lahey Clinic of Boston. Another left to join her husband now in military service. Still another has moved to California. During this past year, the office has likewise been confronted with the necessity of securing a replacement to Miss Cridland, assistant editor of *The Wisconsin Medical Journal,* who resigned in the spring of 1941, and whose position has not since been permanently filled.

The organization of the Society's office is necessarily intricate, due to the many-sided character of its work. Maintaining membership records, collecting dues, providing membership certificates and pocket cards (in 1943 this becomes more involved because of the three certificates now required for life members, members who have a thirty-five year record of membership, and the year-by-year member) requires the full-time attention of one office assistant. The financial affairs of the Society require a considerable amount of attention—invoices must be verified and charged to the proper account, checks written, payroll deductions made as required by law or as imposed by virtue of the emergency, employment reports, state and federal,—these and countless others require more than the half-time service of one person.

In addition, full time stenographic assistance must be provided for both the secretary and the assistant secretary. Filing procedures, details attendant upon the annual meeting and postgraduate clinics, the work involved in the participation of the Society in this emergency period—these duties and others have strained the physical resources of the Society to the utmost.

Hayden Smith, with court reporter abilities, takes hearings on public health matters, proceedings of committees that must be reported, besides assisting in contact and study work with state officers, etc. During 1943, the office will have various legislative hearings to cover as well. Other employes are Merriam Kelly, office manager; Valesca Riggert, membership; Margaret Kracht, assistant to Mr. Larson; and Alberta Marquardt, part-time. In 1942, the total appropriation for the staff was $7,360. This is insufficient, if the Society is to maintain its vital services during this period. Nor will an appropriation at present salary levels permit raises, or an occasional bonus. The secretary suggests that the appropriation under this account be carried at $7,450, and that under Industrial Health there be provided a budgetary allotment of $1,400, recognizing that very properly special provision should be there made for secretarial assistance ..... $ 7,450

Total, staff appropriations $11,600

11. It was moved and seconded by Christofferson–Blumenthal that the Executive Committee be empowered to act in any emergency relating to the retention or employment of office personnel, and that this committee be provided with a contingent fund of $2,000 to be used at its discretion.

III. *Administrative Expense*

12. *Accounting and insurances.*—This item includes provision for the part-time services of the bookkeeper for the books of the secretary and treasurer, the cost of the annual audits, and the various insurances carried by the Society such as fire, workmen's compensation and public liability ---- $ 750

13. *Social security taxes.*—The Society is subject to the social security laws and is complying with the Wisconsin unemployment compensation law. This appropriation is fixed in its nature, but due to our unemployment reserve having now reached its required total, the amount listed is one-half that formerly required ---------- 335

14. *Office*

A. *Rent.*—The present quarters were secured with approval of the Council to reduce fire hazard to irreplaceable and invaluable records in an old building. The total rent of the offices of the State Medical Society and *The Wisconsin Medical Journal* is $2,340, the balance of $540 being paid out of *The Journal* fund ---------- 1,800

B. *Telephone and Telegraph.*—The amount allocated for 1943 is an absolute minimum. The 1942 appropriation was $1,400. This proved insufficient by about $250 -------- 1,400

C. *Supplies and Light.*—This item covers stencils, mimeograph paper, second sheets, typewriter ribbons, and like items of normal office requirements, and office lighting. It is anticipated that the cost of supplies will advance somewhat. However, rising costs may be offset in time by certain economy measures. While the 1942 appropriation proved inadequate, this was due in part to purchases of additional filing material in view of these being no longer manufactured as plants converted to war production 800

D. *Postage and Printing.*—The printing referred to is essentially stationery. The postage bill of a normal outgoing mail of more than fifty pieces, first class, per day, seems to be an irreducible item. In addition, this item covers the membership certificate mailing, correspondence and postage for our bulletins to committees and officers. While some economies are being effected, these will be offset by increased costs that are beyond our power to control. The 1942 appropriation was barely sufficient 2,350

E. *Fixtures and Upkeep.*—The Society finds it essential to purchase a file, and sometimes two, a year; to overhaul two typewriters of seven; and to provide for repair of others; and like incidental expenses of normal upkeep. Because of careful purchasing in 1941 in anticipation of rising prices and scarcity, the normal annual expense of $400 may be distributed over a two-year period ---------- $ 225

F. *Miscellaneous.*—In the statement of the budget figures above, the minimums have been used. Each year, however, finds us confronted with situations, emergent in their nature, requiring a wholly new and unanticipated expense of over-the-budget expenditures. An example, for instance, will be a year when five bulletins to members, costing $600 instead of the budgeted $450, are required. This item is to permit a leeway to this limited extent ---------- 750

Total administrative expense--- $ 8,410

IV. *Membership—special service*

A. *General*

15. *Legal.*—The State Society is frequently called upon by county societies to advise them as to membership rights and related questions. Occasional problems of emergency character are presented, such as that in 1941 when the Society appeared in the Supreme Court on the subject of expert witnesses. The State Society prepares contracts between county medical societies (where arrangements can be made) and local relief authorities for provision of sickness care for those on public assistance rolls. Officers of the Society themselves frequently must resort to legal counsel in order to safeguard the general policies of the Society, and further work carried on under this appropriation includes advice to members concerning problems which affect the profession at large, assistance in interpretation, and participation under various relief laws, analysis of other laws peculiarly affecting the profession of medicine, and compilation of the Blue Book material (1941 appropriation $1,800) ---------- 1,500

16. *Special Bulletins to Members.*—With a membership of 2,550, a single special bulletin to the members costs $150, perhaps more in 1943. Experience of past years indicates annual requirement of at least four of these. A decrease in the number of resident members would permit a smaller appropriation. The 1941 appropriation was $600 ---------- 500

17. *Blue Book Issue.*—This represents but the excess printing and mailing costs for this annual issue of *The Journal,* which is continually revised and new material incorporated. The size of the Blue Book issue has been substantially increased, and reprints of special articles are in greater demand. While the normal budget appropriation has been $600 in the last two years, this is barely sufficient. Due to this and other reasons, the Blue

Book was delayed until the January issue to permit a three-year budget to carry two issues, rather than three issues' cost ..... $ 600

B. *Scientific*

18. *Annual Meeting.*—$1,800 represents the cost to the Society over exhibit income for a normal year.. 1,800

19. *Postgraduate Centers.*—This represents the largest possible loss. In 1941, of $900 appropriated, only about $500 was spent. It would be unwise to reduce the appropriation to less than that suggested, as inclement weather or a similar occurrence may result in a small registration with a consequent large financial loss. It is suggested that any surplus be transferred to the annual meeting account automatically 900

20. *Wisconsin Medical Journal.*—Previous to 1942, *The Journal* was self sustaining from its own funds supported by an appropriation of approximately 75 cents per member from the general fund. In 1941, the House of Delegates recognized the need for a larger amount, due to the volume of scientific material available but not published because of cost. Thus the appropriation for 1942 consisted of $2,100, still well within $1.00 per member. Your secretary suggests a larger allotment for 1943, based on several circumstances. The most important of these concerns the position of assistant editor. It must be recognized that the publication of *The Journal* is a most technical and detailed task. All scientific material must be carefully edited before being sent to the printer, to ascertain that references are correctly noted, and that spelling and grammatical construction are proper. Similar care must be taken with reference to all other material, although not so painstaking a task. Advertising revenues total approximately $9,000 yearly, and circulation exceeds 3,000. All in all, it may fairly be said that *The Journal* constitutes a business venture in its own right. It is particularly complicated in these times, as a result of various government regulations, the fact that members in service are particularly desirous of receiving their copies regularly and are themselves being constantly shifted to new locations, and the like.

Various experiments were tried during 1942 to carry *The Journal* within the staff structure previously developed, with an assistant editor receiving a salary of $1,800. This has proved impractical, and for the first time a man, R. O. McLean of Madison, has been employed to supervise *Journal* activity, including advertising solicitation and the like. In addition, he is gradually being trained to assist in other office procedures directly related to the publication of *The Journal.* The present remuneration for this position is $2,400, and although it is apparent that increased advertising revenue will in time fully make up the difference, this cannot be counted upon at present. It is suggested therefore that an increased appropriation be provided for 1943 ..... $ 2,600

$ 7,900

V. *Public health, special services*

A. *Normal service*

21. *Hygeia.*—This is authorized as a standing appropriation to present at Christmas time a year's subscription to all state officers, the nine state teachers' colleges, and certain others who have to do with public health problems and procedures 275

22. *Health and Public Instruction.*—This item represents the printing, paper and postage costs of furnishing a weekly story on health and its further attainment to weekly and daily papers of the state. Included is the amount required to operate health exhibits at county fairs and the state fair 1,135

23. *Lay Publications.*—This represents the cost of furnishing health studies, documents and pamphlets to state officers and others who have to pass upon health procedures and proposals (1941 appropriation, $450) 400

24. *Bulletins to Members.*—Cost of bulletins dealing with proposed changes in public health laws and rulings 500

25. *Special Reports in The Journal.*—Supplements or insert sections dealing with state and national health problems 250

26. *Telephone and Telegraph.*—Dealing with health legislation 450

27. *Services, general counsel.*—Analyzing all legislation to ascertain which deals with health subjects, compilation of data concerning legal effect of changes proposed, and assisting in discussion with and in official bodies 1,500

B. *Voluntary sickness insurance trials*

In 1940 this item was budgeted at $3,700, of which amount but $2,643.77 was used. In 1941, of the appropriation of $2,000, only $700 was used. As the Council is aware, numerous negotiations have been had with the Farm Security Administration, and still a further plan appears imminent in 1943. The House of Delegates suggested the importance of this work be recognized by appropriate budgeting allotment. The 1942 balance (about

$1,200) should be considered as a carry-over appropriation to 1943, and an appropriation of $1,750 should be made (amount used in budget suggested to 1942 House of Delegates)	$ 1,750
Total, public health, special services, (1941 total, $6,110)	$ 6,260
VI. *Industrial health program*	
A. *Panel Preparation and Distribution* The 1942 panel preparation has been delayed so that, if necessity indicates, panels may be printed but twice over the three year period 1942–1944, inclusive. Thus, the 1942 appropriation should be treated as a carry-over, with a similar appropriation for 1943	4,200
B. *Medical Examination in Industry* Participation in health projects for industry is an immediate activity of the Society. While the unusued balance of the carry-over appropriation for 1941 was sufficient for 1942, it appears that the 1942 appropriation should be carried over, together with the appropriation suggested to the 1942 House of Delegates, for 1943. This will permit the services of an additional employe as suggested in item II(10)	2,500
Total Item VI	$ 6,700
Estimated income for 1943	*$56,000
Proposed budget total	52,420
	$ 3,580

* Or more.

15. The Annual Meeting and the Council Award

Mr. Larson explained the procedures for selecting a recipient of the Council Award and asked that suggestions be sent to the secretary as soon as possible.

16. Council Committee Appointments

The following committee appointments were announced by Dr. Gavin: *Executive Committee of the Council*—Doctors W. T. Clark, Janesville; A. H. Heidner, West Bend; and Robert W. Blumenthal, Milwaukee, to succeed themselves. *Auditing Committee*—Doctors H. H. Christofferson, Colby; G. W. Krahn, Oconto Falls; and C. W. Eberbach, Milwaukee. *Conference Committee on Open Panels*—Doctors R. M. Kurten and John H. Karsten. *Committee on Wisconsin Hospital and Medical Payments Plan*—Doctors C. H. Andrew, Platteville, and A. E. Rector, Appleton. *Committee on War Participation*—President of the Society, President-elect, Chairman of the Council, State Consultant of Procurement and Assignment Service, and the Secretary of the Society, ex-officio. *Subcommittee on Procurement and Assignment Service*—Drs. E. J. Carey, Milwaukee, chairman; H. M. Coon, Madison; J. W. Prentice, Ashland; F. X. Pomainville, Wisconsin Rapids; P. R. Minahan, Green Bay. *Subcommittee on Replacements*—Drs. R. W. Blumenthal, Milwaukee, chairman; S. D. Beebe, Sparta; E. C. Cary, Reedsville; H. A. Sincock, Superior; A. A. Cantwell, Shawano. *Subcommittee on Civilian Defense*—Drs. J. S. Supernaw, Madison, chairman; R. W. Blumenthal, Milwaukee; V. E. Ekblad, Superior; T. C. Hemmingsen, Racine; A. G. Koehler, Oshkosh; F. G. Anderson, Eau Claire; C. N. Neupert, Madison; J. W. Lambert, Antigo.

17. The Physician Manpower Situation in Wisconsin and Policies of the Procurement and Assignment Service for 1943

Chairman Gavin called upon Dr. R. E. Fitzgerald, State Consultant for the Procurement and Assignment Service, to report on activities during 1942 and the anticipated problem in 1943. Dr. Fitzgerald advised the Council that a total of 577 men were reported to be required from Wisconsin during the early part of 1942. This objective, Dr. Fitzgerald advised, had been met.

The tentative objective for 1943 of 300 Wisconsin physicians had been established by Procurement and Assignment. The means of obtaining our required medical officers in 1943 have been changed from that which had been operative in 1942. Medical officers' recruiting boards would not be reinstated in 1943, but it was anticipated that each month a request would be received from the national office of Procurement and Assignment for a specified list of physicians. The state Procurement and Assignment officer has been advised that to obtain the required number from physicians under 37 years of age, allowing for disqualification due to physical reasons, and those who are deemed to be essential for teaching, war work, and civilian needs, approximately 55 per cent of the physicians of that military age might generally be found to be available.

When the list of physicians received from the national office of Procurement and Assignment have been reviewed as to availability, those men who are determined to be available are reported to Washington, D. C. The Procurement and Assignment Service will then advise the individual physician by postcard that he is considered available for service. At that time, the physician deemed to be available indicates to the State Consultant of Procurement and Assignment, Dr. R. E. Fitzgerald, the type of service or branch of service he prefers. Dr. Fitzgerald then forwards this indication to the proper branch of the service. The physician will then be asked by the recruiting officer to complete his application for service.

A ratio of one physician to every 1,500 civilian population has been established as the minimum for 1943. The more populous cities are expected to furnish the bulk of physicians for the armed forces in 1943.

18. War Membership Problem

The Council's attention was called to the membership problem which was created by the entry of physicians into the armed services directly from internship. When this occurs, physicians cannot meet some of the necessary membership requirements for joining a county medical society. A rather

frequent provision requires that a physician must reside in a community for one year before he becomes eligible for membership.

The Council, being the legislative body between sessions of the House of Delegates, upon motion by Christofferson–Fitzgerald, adopted unanimously the following by-law:

Section 11, Chapter X of the By-laws of the Society is created to read as follows:

"Section 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its Constitution and By-laws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

"No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service."

19. Recommendation of Conference Committee on Open Panels

The Conference Committee on Open Panels recommended to the Council that the names of certain physicians be removed from their respective county panels due to failure to submit reasonable reports as requested by the employer, the insurance carrier, the Industrial Commission, the secretary's office and the Councilor in whose district the physician or physicians reside. Upon motion by Pippin–O'Leary, the following resolution was adopted:

"*Resolved* that it is the judgment of the Council that all reasonable efforts having been made to secure reports, after contacting the councilors concerned, they should be removed from the currently posted panels, and those to be prepared this year, and such physicians are to be reinstated only after Council action."

20. Election of Councilor to fill the unexpired term of Captain J. W. Lambert, Antigo

Chairman Gavin read a telegram from Captain Lambert tendering his formal resignation due to his absence from the state for military service. In accordance with Section 7, Chapter 6 of the By-laws, upon motion made by Jegi–Blumenthal, Dr. J. D. Leahy of Park Falls was unanimously elected to fill the unexpired term of Councilor J. W. Lambert.

21. National Physicians Committee

Upon suggestion of Chairman Gavin, the executive committee was designated to receive all questions pertaining to the National Physicians Committee. A motion directing the Executive Committee to act in this capacity was adopted.

22. Resolution Honoring Dr. C. A. Harper

Dr. Kurten reported that the special committee appointed by the chairman had prepared a resolution commending Dr. C. A. Harper for his thirty-nine years of service as State Health Oficer. The resolution reported by the committee is as follows:

"The Council of the State Medical Society of Wisconsin notes with regret the resignation of Dr. C. A. Harper, for thirty-nine years State Health Officer for the State of Wisconsin. On this occasion, the Council desires to express to Dr. Harper the deep appreciation of the medical profession of this state for his many years of devoted services to the citizens of the state as the custodian of their health and health problems.

"The Council takes comfort in the knowledge that the invaluable services of Dr. Harper are to be retained for the citizens by his retention in a consulting capacity as public health advisor, and wishes for him many years of health and prosperity."

23. Compensable Hernia

Councilor Pechous, at the request of the Kenosha County Medical Society, asked that a special study be made of the coverage of employment-related hernias. This question, together with detailed information concerning the problem, was to be referred to the Committee on Industrial Health with a request that a conference be held with the Industrial Commission and others. As soon as a definite conclusion was reached, the membership was to be apprised of the findings of the committee.

24. County Secretaries

Councilor Hough emphasized the importance of keeping county medical society secretaries informed of important actions, trends and medical matters. Attention was called to the secretaries' conference to be held at the time of the Annual Meeting, and Councilors were urged to recommend questions for inclusion on the program.

25. Life and Affiliate Membership

The Council by acclaim requested that the names before the Council for life and affiliate membership be referred to the Councilor in whose district the physician resided, and, upon the individual written recommendation of the Councilor, the Council would accept as its action the recommendation of the Councilor in whose district the applicant resided.

26. Adjournment

The meeting adjourned at 4:00 p. m.

C. H. Crownhart
Secretary

Approved:
S. E. Gavin
Chairman of the Council

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

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Mrs. A. J. McCarey, Green Bay

Report of Midyear Meeting of Board of Directors

By MRS. R. M. KURTEN
Racine

ON JANUARY 28, twenty-six members of the Woman's Auxiliary to the State Medical Society of Wisconsin assembled at the Hotel Schroeder, Milwaukee, for the midyear meeting of the Board of Directors. This group is made up of state officers, chairmen of standing committees, and presidents of county auxiliaries.

Immediately following the luncheon, Mrs. G. E. Stoddart, state commander of the Women's Field Army, discussed the program and aims of the Women's Field Army and that part which is played by members of the Medical Auxiliary.

Following roll call and the reading of the minutes of the postconvention Board meeting, Mrs. E. S. Schmidt, president, cordially greeted the women present and expressed regret for the absence of some members due to illness and conflicting engagements. Mrs. Eben J. Carey, national president-elect of the Woman's Auxiliary, and Mrs. R. E. Fitzgerald, national parliamentarian, were present at this meeting. Members missed their president-elect, Mrs. O. M. Layton of Fond du Lac, and later in the meeting moved that a message of sympathy be sent to her over the recent loss of her husband, Dr. O. M. Layton.

Reports of Officers and Chairmen

In her report, Mrs. Schmidt announced the appointment of Mrs. A. J. McCarey, Green Bay, as chairman of the newly created Special Committee on War Activities and explained the purpose of this committee. She thanked the chairmen for their cooperation and offered additional handbooks for their use. It was pointed out that complete lists of county officers and committee chairmen have not yet been received from every unit. Mrs. Schmidt listed several county auxiliaries which she had visited and described the midyear National Board meeting in Chicago, which she attended on November 20.

The report of the treasurer, Mrs. Charles Fidler of Milwaukee, was accepted. After a lengthy discussion of the matter of service wives and their dues, the board members voted that, if the counties wish to have the names of their service members carried on the state and national rolls, they (the county units) are obliged to pay the state and national dues for such members.

Mrs. J. S. Supernaw, past-president, reported on a meeting which she attended on December 10 in the offices of the State Board of Health, representing Mrs. Schmidt. Members of various women's clubs were invited to discuss with Dr. Harper methods by which the existing health standards in Wisconsin can be maintained.

The corresponding secretary, Mrs. L. D. Quigley of Green Bay, read several communications received from the national Aux-

iliary office, one of which announced the national meeting on June 7, 8 and 9 at the Drake Hotel, Chicago.

The reports of all state officers were accepted.

The nominating committee, under the chairmanship of Mrs. A. H. Barr, was unable to make a report at this time but stated that the counties have been contacted for the names of delegates to the national convention.

The first report of the War Activities Committee was given by Mrs. A. J. McCarey who has devoted much time and thought to this subject. She stated that all county chairmen have been instructed to keep a record of service hours and furnish such information to her. A survey of individual capabilities is being made in each auxiliary to facilitate the war work, and many different types of activities have been planned for the guidance of county groups.

The report on circulation of *The Bulletin,* which was presented by Mrs. W. A. Wagner of Oshkosh, indicated that all state officers and committee chairmen have been contacted, and as a result, she has received forty-one subscriptions, thirty-five of which are new.

In the absence of the chairman, Mrs. L. V. Sprague of Madison, Mrs. Supernaw gave a report on legislation. The matter of joining the Wisconsin Women's Legislative Council was discussed, and the Board voted to take out a membership in the name of the Woman's Auxiliary. The work of the council is informative, rather than policy-making, and it was believed that membership in the council would develop a greater interest among Auxiliary members in current legislative affairs. Mrs. Schmidt urged that legislative chairmen be appointed in all county auxiliaries.

The resignation of Mrs. O. W. Friske, Beloit, as organization chairman was accepted with regret, and the Board gave the president the power to make an appointment to fill this vacancy. In Mrs. Friske's absence, Mrs. Schmidt told about the formation of the new Crawford County Medical Auxiliary in December.

Mrs. D. B. Dana's report on press and publicity was read and accepted. She urged that county news reports be made promptly.

Health education and war programs form the basis upon which programs are being planned this year, according to the report of Mrs. D. F. Gosin, Green Bay, program chairman. She wished county auxiliary officers to be reminded that speakers can be secured through her.

In her report on public relations, Mrs. R. D. Champney, Milwaukee, made particular mention of the new radio program, "Doctors at War," heard each Saturday at 5:00 p. m. Eastern war time, and at 8:00 p. m. by transcription.

Mrs. Schmidt announced the appointment of Mrs. H. O. Zurheide, Milwaukee, as convention chairman. Tentative plans for the convention are to be made shortly.

A number of reports of county presidents were presented during the course of the meeting. They reflected an alertness to the opportunities for service in their communities, especially during wartime, and a determination to further the aims of the Auxiliary.

County Auxiliary Proceedings

Brown—Kewaunee—Door

Miss Anna Hassels, supervisor of nurses of the Green Bay Health Department, was guest speaker at a luncheon meeting of the Brown–Kewaunee–Door Medical Auxiliary held at the Y. W. C. A., Green Bay, recently. She discussed the new school health program.

Following the meeting, members folded surgical dressings, a project of the auxiliary.

Dane

The Woman's Auxiliary to the Dane County Medical Society held a luncheon meeting at the home of Mrs. J. S. Supernaw, Madison, on February 8. Mrs. H. Kent Tenney, chairman of hostesses, was assisted by Mmes. G. A. Cooper, A. G. Sullivan and R. L. McIntosh.

Mr. Charles H. Crownhart, secretary of the State Medical Society, spoke to the group on "The Medical Profession and the War."

Dodge

Mrs. R. E. Schoen, Beaver Dam, president of the Dodge County Auxiliary, reports that this unit has

decided to limit its activities to war work and to hold fewer meetings because of transportation difficulties.

Fond du Lac

At a joint meeting of the Fond du Lac County Medical Society and the Woman's Auxiliary, which was held at the Hotel Retlaw on January 28, Mrs. G. E. Stoddart, state commander of the Women's Field Army, appeared as guest speaker.

Mrs. Stoddart, who has just been appointed regional deputy commander of the American Society for the Control of Cancer, stressed the value of instruction in high school. "It is unpatriotic to neglect the prompt diagnosis of cancer at any age," said Mrs. Stoddart.

The region of the national society of which Mrs. Stoddart has been made deputy commander includes Wisconsin, Michigan, Iowa, Illinois, Minnesota, South Dakota, Kansas, Nebraska and Missouri.

After the cancer talk, Mr. James Nelson presented a public health lecture. A musical program which followed consisted of vocal solos by Miss Francis Secor, accompanied by Mrs. Esther Temple, marimba selections by Miss Gladys Woeschnick, and musical and dance numbers by the children of Dr. and Mrs. P. G. McCabe.

Kenosha

A two-act play, read by Mrs. M. E. Baker, entertained members of the Woman's Auxiliary to the Kenosha County Medical Society who met at the home of Mrs. A. J. Randall on the evening of February 2. Mrs. L. H. Lokvam, program chairman, introduced Mrs. Baker. The play was entitled "Suppressed Desires."

At the business meeting various reports were received from committee chairmen. Mrs. A. L. Mayfield, victory reporter, spoke of the rubber conservation program for defense.

Hostesses for the evening were Mrs. L. M. Rauen, Mrs. H. M. Ripley, and Miss Eva Randall.

La Crosse

The Woman's Auxiliary to the La Crosse County Medical Society held a one o'clock luncheon at the home of Mrs. H. E. Wolf, La Crosse, on January 20. Following the luncheon, Mrs. Rose Simones sang three selections, accompanied by Miss Elizabeth George. Mrs. J. R. Richter, Chaseburg, was scheduled to entertain the members with readings, but because of transportation difficulties she was unable to attend.

The auxiliary voted $75 to the Camp McCoy camp and hospital committee to be used for the nurses' recreation building. Mrs. Wolf spoke on various phases of Red Cross nursing, nurses' aides, home nursing, and the enrollment of graduate nurses in the armed services.

Mrs. Wolf was assisted at the luncheon by the social committee, under the chairmanship of Mrs. R. C. Johnston, La Crosse.

Manitowoc

The book, "Castor Oil and Quinine," by George Wonson Vandegrift, M. D., was reviewed by Mrs. E. W. Huth, Valders, at a meeting of the Manitowoc County Medical Auxiliary on January 20 at the home of Mrs. F. E. Turgasen, Manitowoc.

Hostesses who assisted at the luncheon were Mrs. A. J. Shimek and Mrs. T. A. Teitgen.

When the Woman's Auxiliary to the Manitowoc County Medical Society held a joint meeting with the Manitowoc Federation of Women's Clubs at the First Presbyterian Church on February 8, Dr. W. W. Bauer, director of the Bureau of Health Education of the American Medical Association, was the guest speaker. Auxiliary members reported that the talk was enthusiastically received and that the meeting was very successful.

Using the title "Women in a World at War," Dr. Bauer spoke of the work of the WAVES and WAACS, but he wished the greatest emphasis placed on the "WIVES." "If you are one of those women who have small children, and a home which needs your care, the most important thing that you can do regardless of the possible scorn of uniformed friends or alluring salaries offered by industrial plants is to stay at home and bring up those children," he said. When applause met Dr. Bauer's statement, he added, "Don't break up your home. It's what we are fighting for!"

Dr. Bauer told his audience that this generation is the healthiest in the history of America, even though the high standard can yet be improved. He warned that the menaces of the next years will be tuberculosis, poor housing conditions in congested areas, and the spread of epidemics. "It is up to the women to watch these things," he declared.

"Above all, we must keep our sense of humor. The worst beating we civilians have to take is the psychological beating of radio and newspaper war stories. Don't let yourself be worn down by fatigue; be informed, but not obsessed by the war, and take time to do the things you like to do sometimes, even if it is only reading 'whodunits' or working crossword puzzles."

Milwaukee

Two hundred members and guests attended the monthly meeting of the Woman's Auxiliary to the Medical Society of Milwaukee County on February 12, Lincoln's Birthday, at the Hotel Schroeder. The Lincoln motif was carried out in the luncheon and program. Among the guests were members of the Washington–Ozaukee and Waukesha County Medical Auxiliaries and members of the Milwaukee Dental Auxiliary.

The guest speaker was Commander Bart W. Hogan, Senior Medical Officer aboard the aircraft carrier Wasp, which was torpedoed and sunk in the Solomon Islands. He was introduced by Dr. Eben J. Carey, dean of the Marquette University School of Medicine and president of the Medical Society of

Milwaukee County. Commander Hogan's stirring story was heard with deep interest by his audience.

Members of this auxiliary who are nurses have been asked to fill out questionnaires which will be used in a survey of nursing resources in Wisconsin. Mrs. Edith M. Partridge, Cudahy, an auxiliary member and executive secretary of the Wisconsin State Nurses' Association, has charge of this survey.

Racine

The Reverend Clarence Seidenspinner discussed the works of contemporary poets before members of the Racine County Medical Auxiliary on January 11 at St. Luke's Hospital library, Racine. It was the auxiliary's first meeting of the year. Reverend Seidenspinner illustrated his talk with excerpts from the poems of Edna St. Vincent Millay and Robert Jeffers.

Members discussed plans for assisting in the war effort and reviewed their current projects.

On February 8, the monthly meeting of the Woman's Auxiliary to the Racine County Medical Society was held at the Hotel Racine. Hostesses were Mmes. T. C. Hemmingsen, R. O. Peterson, E. Tompach, H. G. Walters, J. M. Albino, F. B. Marek, R. W. Kreul, N. B. Wagner and A. W. Adamski.

Following luncheon, Mrs. L. L. Freeman spoke on current legislative activity, urging the cooperation of each individual in the maintenance of a democracy.

Members were asked to participate in folding surgical dressings and obtaining donors for blood banks.

Rock

Fifteen members and two guests attended a meeting of the Woman's Auxiliary to the Rock County Medical Society on January 26 at the Janesville Woman's Club.

Following a six-thirty dinner, Dr. Thomas J. Snodgrass, chairman of Emergency Medical Service for Rock County, explained the work of the service and the function of the control center. He was assisted by Miss Dorothea Boone.

Two members of this auxiliary, both former nurses, are in charge of local casualty stations. Other members will assist at Pinehurst Sanatorium.

Seventy-two *Hygeia* subscriptions were reported at the meeting by the chairman.

Sauk

On January 10, the monthly meeting of the Sauk County Woman's Auxiliary was held at the Warren Hotel, Baraboo. During the business meeting which followed dinner, Mrs. Harry Vander Kamp was appointed chairman of war activities.

Members of this group also voted to offer their services to the Ration Board during coming weeks.

Winnebago

Auxiliary members joined members of the Winnebago County Medical Society for dinner at the Valley Inn, Neenah, on January 6. Later they gathered at the home of Mrs. R. H. Quade for their regular meeting. A $10 donation was voted to the Red Cross for soldiers' kits.

In a discussion of "Good Reading for Children," Mrs. W. B. Hildebrand, Menasha, explained the different types of books for young people. She stressed the importance of reading to very young children, and stated that a few good books do more for a young reader than many books of a lower caliber.

Following their business meeting, members of the medical society joined their wives at the Quade home.

Society Proceedings

Ashland—Bayfield—Iron

"Medical Aspects of War Gases" was the subject of the talk given by Dr. William J. Tucker, Ashland, at a business and dinner meeting of the Ashland–Bayfield–Iron County Medical Society at the Knight Hotel, Ashland, on February 4.

The business meeting was featured by the election of the following officers, all of Ashland.

President—Dr. John W. Prentice
Vice-president—Dr. Andre H. Lamal
Secretary—Dr. Roll O. Grigsby

Dr. Grigsby was chosen delegate, and Dr. Prentice, alternate.

Brown—Kewaunee—Door

At a dinner meeting of the Brown–Kewaunee–Door County Medical Society at the Beaumont Hotel, Green Bay, on February 11, Dr. Raymond H. Quade, Neenah, gave an illustrated talk on "Surgical Relief of Pain." Twenty-four members and guests attended.

Chippewa

Dr. William C. Bernstein, St. Paul, was the featured speaker at the annual meeting of the Chippewa County Medical Society held January 19 at the Hotel Northern, Chippewa Falls. Dr. Bernstein spoke on the surgical removal of hemorrhoids and other lower bowel pathology.

During the business meeting which followed a 6:30 dinner, the following officers were elected:

President—Dr. Lyman W. Picotte, Chippewa Falls
Vice-president—Dr. C. B. Hatleberg, Chippewa Falls

Secretary-Treasurer—Dr. Clarence E. Zenner, Cadott
Delegate—Dr. A. J. Somers, Chippewa Falls

A good attendance marked the annual meeting, and several physicians from Eau Claire were present to see and hear Dr. Bernstein.

Dane

The Dane County Medical Society held its regular meeting Tuesday evening, February 3, at the Station Hospital of the Army Air Forces Technical Training Command at Truax Field upon invitation from Lieutenant Colonel M. U. Prescott, M. C. About 125 members, guests, and officers of the Medical Corps were present.

The following program was presented:

1. Control of Venereal Disease in the Army—Major Dorrin F. Rudnick
2. Physical Requirements of the Flier—Major Herbert D. Glick
3. Psychiatric Problem Seen in the Army—Major John Chornyak
4. Primary Atypical Pneumonia in the Army—Major Charles S. Higley
5. Common Surgical Conditions Seen in the Army—Major Bernard B. Larsen

Refreshments were served following the meeting, and a tour of inspection was allowed through certain portions of the hospital.

Dodge

Instead of a speaker, presentation of case histories by members of the Dodge County Medical Society featured the meeting of the Society at the Hotel Rogers, Beaver Dam, on January 28.

Douglas

The Douglas County Medical Society met at Hotel Superior, Superior, on February 3 in conjunction with the Northern Wisconsin Dental Society. Dr. C. W. Waldron, Minneapolis, spoke on traumatic injuries of face and teeth.

Eau Claire—Dunn—Pepin

At a dinner meeting held at the Eau Claire Hotel, Eau Claire, members of the Eau Claire–Dunn–Pepin County Medical Society heard tropical medicine discussed by Dr. Marcos Fernan–Nunez of the Marquette University School of Medicine, Milwaukee.

Fond du Lac

Mrs. E. A. Stoddart of the Women's Field Army for the Control of Cancer gave an informal address on the work of the Women's Field Army at a joint meeting of the Fond du Lac County Medical Society and the Woman's Auxiliary on January 28 at the Retlaw Hotel, Fond du Lac. The meeting was followed by musical and novelty entertainment. Forty-five persons represented the two groups.

Green Lake—Waushara

On Tuesday, January 19, the annual business meeting and election of officers of the Green Lake–Waushara County Medical Society was held at the Hotel Whiting in Berlin. The following officers were elected:

President—Dr. Shirley L. Hadden, Wild Rose
Vice-president—Dr. Herman C. Koch, Berlin
Secretary-Treasurer—Dr. Mildred Stone, Berlin
Censor—Dr. Orvil O'Neal, Ripon

Program meetings will be held in the near future in conjunction with the medical societies of adjoining counties.

Jefferson

At their February meeting, the Jefferson County Medical Society was entertained at dinner at the Washington Hotel, Watertown. Dr. Frederic E. Mohs of the University of Wisconsin Institute of Cancer Research gave a talk on his particular interest in cancer surgery.

At its dinner meeting on January 21 at Lake Mills, members of the Jefferson County Medical Society heard two addresses. Dr. Arnold S. Jackson, Madison, spoke on "The Acute Surgical Abdomen," and Dr. John Gallagher, Madison, on "Emergency Case of Fractures and Burns." The group also enjoyed a color movie of deep sea fishing off the Florida east coast shown by Dr. Jackson.

Kenosha

Dr. Clifford M. Creswell, Kenosha, and Dr. George Schulte, Kenosha, were honor guests at a dinner given by the Kenosha County Medical Society on January 21 at Kenosha. Dr. Creswell and Dr. Schulte, who are leaving for service in the United States Navy, were presented with gifts of money. Twenty-two members were present.

La Crosse

The monthly meeting of the La Crosse County Medical Society was held on Tuesday evening, February 9, at the Hotel Stoddard. Captain F. R. Fitch of Camp McCoy, Sparta, spoke on "Some Problems in Syphilis."

Milwaukee

The Medical Society of Milwaukee County held its monthly meeting at the Milwaukee Athletic Club on Friday, February 12. Fifteen minutes of discussion on preventive medicine was highlighted by a talk on "Parasitic Infections" by Dr. H. W. Brown, Dean of the School of Public Health, the University of North Carolina. Featuring the program was a speech by Commander Bartholomew W. Hogan, Senior Ship Surgeon on the Aircraft Carrier "Wasp," who spoke on "The Doctor in a Naval Campaign."

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Outagamie

Dr. Robert C. Brown, Green Bay, spoke on "Diseases of the Hip" at a dinner meeting of the Outagamie County Medical Society at the Conway Hotel, Appleton, on February 18.

Rock

Dr. W. O. Thompson of Presbyterian Hospital, Chicago, gave an address on hypogonadism at the monthly dinner meeting of the Rock County Medical Society held at the Monterey Hotel, Janesville, on January 26. Thirty-five members were present.

Sheboygan

Mr. Charles H. Crownhart, secretary of the State Medical Society of Wisconsin, and Mr. Robert B. Murphy, counsel for the State Society, were guest speakers at a meeting of the Sheboygan County Medical Society at the St. Nicholas Hospital, Sheboygan, on February 8. Mr. Crownhart discussed the general trend of prepaid surgical benefits and past experience with such plans in the state of Wisconsin. Mr. Murphy outlined the proposed prepaid surgical plan which the Sheboygan County Medical Society intends to present to the Kohler Workers' Association. About twenty members were in attendance.

Waukesha

At the annual meeting of the Waukesha County Medical Society held in December, the following officers were elected:

President—Dr. James Christiansen, Waukesha
Vice-president—Dr. Erwin C. Van Valin, Sussex
Secretary-Treasurer—Dr. James F. Wilkinson, Oconomowoc
Delegate—Dr. Richard E. Davies, Waukesha
Alternate-delegate — Dr. Herbert T. Barnes, Delafield
Censors—Dr. T. H. Naumacher, Oconomowoc (three years); Dr. Herbert T. Barnes, Delafield (two years); Dr. Joseph B. Noble, Waukesha (one year)

Dr. William O. Hiebuhr, Waukesha, Dr. Robert J. Dancey, Statesan, and Dr. Philip M. Wilkinson, Oconomowoc, were elected to membership at the December meeting, and Dr. L. L. Sanford, Statesan, at the January meeting.

Winnebago

Illustrating his talk with lantern slides, Dr. Raymond H. Quade, Neenah, spoke on "Brain Tumor" at the meeting of the Winnebago County Medical Society held February 4 at the Hotel Athearn, Oshkosh. The meeting was well attended.

Dr. Alvin G. Koehler, Oshkosh, was elected as the Society's delegate, and Dr. J. P. Canavan, Neenah, was chosen alternate.

Ninth Councilor District

The program of the winter meeting of the Ninth Councilor District was a symposium on arthritis, headed by Dr. Bruno Leichtentritt, Fellow of the Children's Fund of Michigan. The program was arranged as follows:

3:30 p. m. St. Joseph's Hospital School of Nursing
X-ray Diagnosis of Arthritis
Dr. R. P. Potter, Marshfield
Classification and Diagnosis of Arthritis
Dr. Bruno Leichtentritt
Presentation of Cases
Dr. K. H. Doege, Marshfield
Discussion of Cases
Dr. Bruno Leichtentritt

6:30 p. m. Dinner at the Hotel Charles, followed by the evening program

7:30 p. m. Treatment of Arthritis with Special Consideration of Gold Therapy
Dr. Bruno Leichtentritt
X-ray Treatment in Arthritis
Dr. J. M. Wickham, Marshfield
Some Orthopedic Aspects of Arthritis
Dr. R. W. Mason, Marshfield

News Items and Personals

Dr. G. Foard McGinnes, Nashville, Tennessee, has been appointed Director of Medical and Health Service of the midwestern area of the American Red Cross with headquarters in St. Louis. Wisconsin is included in this area.

Since 1929, Dr. McGinnes has been Director of Venereal Disease Control Service in the Tennessee Department of Public Health, Associate Professor of Preventive Medicine of the University of Tennessee, and Chief of the Department of Siphilology at Meharry Medical College. Prior to 1929, he was with the Virginia State Department of Health as Director of the Bureau of Communicable Disease.

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Replacing *Dr. Edwin H. Jorris*, now with our armed forces, *Dr. Allen A. Filek*, Green Bay, has been appointed Director of the Division of Tuberculosis and the Division of Local Health Services of the State Board of Health. The appointment was made by *Dr. Carl Neupert*, State Health Officer.

For the last six and a half years, Dr. Filek has been District Health Officer for the sixth sanitary

(Continued on page 356)

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The fat of Similac has a physical and chemical composition that permits a fat retention comparable to that of breast milk fat (Holt, Tidwell & Kirk, Acta Pediatrica, Vol. XVI, 1933) . . . In Similac the proteins are rendered soluble to a point approximating the soluble proteins in human milk . . . Similac, like breast milk, has a consistently ZERO curd tension . . . The salt balance of Similac is strikingly like that of human milk (C. W. Martin, M. D., New York State Journal of Medicine, Sept. 1, 1932). *No other substitute resembles breast milk in all of these respects.*

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Prescribe Journal-advertised products and you prescribe the best.

Shown here is the poster design selected for the seventh annual Enlistment Campaign of Women's Field Army of the American Society for the Control of Cancer. The appeal will be conducted throughout Wisconsin April 1 to 30 by the Wisconsin Women's Field Army.

The month of April was set aside by Congress in 1938 as "Cancer Control Month." The disease is the second highest cause of death in the United States, as well as in Wisconsin, killing 160,000 men, women and children annually in the United States and 4,342 in Wisconsin, (1942 provisional figure). Authorities declare that between half and two-thirds of these deaths are preventable. A more vivid idea of this enormous and needless toll may be gathered from the fact that our casualty list for the first year of the war totaled only 50,000.

"What Everyone Should Know About Cancer" is the title of the book that heads the literature for the 1943 campaign. "Cancer in Wisconsin" is the title of a film strip which is available on request to all members of the Society. This strip, together with a projection lantern and manuscript, may be obtained by writing to the office of the Society in Madison.

The following article should prove of interest because it expresses so well the attitude that has been prevalent among Wisconsin physicians for many years.

Behind the Doctor

By C. C. LITTLE, D. SC.

Managing Director of the American Society for the Control of Cancer

IN ANY Democracy, the forces that stand behind the doctor are quite as important as the training and ability of the doctor himself. Among the public health movements in the United States, no group has recognized this basic principle more promptly or more completely than the American Society for the Control of Cancer in conducting its nation-wide educational campaign against that disease.

In 1936, the Society organized as a practical working unit of lay people what it called the Women's Field Army Against Cancer. From the very outset, it was specified that this group of lay workers in the educational field should be guided by governing bodies, and the majority of whose members should be medical men or women. The Society and the Field Army thus definitely committed itself to a policy of standing back of the doctor in the fight against cancer. [Ed. Note: In Wisconsin, the Society's Committee on Cancer is the Executive Committee of the Women's Field Army.]

The wisdom of this attitude has been amply proven. Today doctors all over the United States report a constantly increasing flow of early cancer cases to their offices for diagnosis and treatment. Since the prospect of cure of cancer is directly related to the observation and treatment of the disease in its early stages, this evidence of practical value of the Women's Field Army work has convinced the medical organizations of counties and states throughout the Union that real progress can be made in the conquest of the disease.

The mutual benefits to both the patient and the profession have been great. Either group by itself could never be as strong or effective as in close cooperation with the other.

In response to requests from pediatricians, we are now also marketing PABENA—precooked oatmeal, enriched with vitamin and mineral supplements. PABENA closely resembles Pablum in nutritional qualities, and offers the same features of thorough cooking, convenience and economy. Supplied in 8-ounce cartons. Samples on request.

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NEWS ITEMS AND PERSONALS—Continued

district in Wisconsin. During the two preceding years, he was a practicing physician in southwestern Wisconsin.

Dr. Filek received his Master's degree in public health at the University of Michigan. He is a graduate of Rush Medical College.

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The Turkey club and the directors of the Bank of Newburg surprised *Dr. Herman F. Weber*, Newburg, at a dinner on Wednesday, February 3, in honor of his seventy-fifth birthday. Among the guests were *Dr. Albion H. Heidner* and *Dr. Kilian T. Bauer* of West Bend.

One of the oldest active practitioners in Washington County, Dr. Weber has been a practicing physician in Newburg for the past forty-seven years. He is a graduate of the Wisconsin School of Pharmacy and the College of Physicians and Surgeons, Milwaukee.

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Dr. Leo J. Moriarty, Two Rivers, was admitted as a fellow of the American College of Surgeons at a meeting of its board of regents on December 15, 1942. He is the fourth practicing physician of Manitowoc County to acquire the honor. Others are *Dr. Alfred P. Zlatnik* of Two Rivers and *Dr. William E. Donohue* and *Dr. Reginald W. Hammond* of Manitowoc.

Dr. Moriarty has been a practicing physician at Two Rivers since 1922. He is a graduate of the Marquette University School of Medicine.

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Dr. John J. Rehorst, Fond du Lac, has been appointed health officer of that city in a part-time capacity until a full-time city physician and health officer can be selected. The appointment fills a vacancy which has existed since *Dr. Robert L. Dana* obtained a leave of absence to enter military service.

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A meeting of the West Bend Kiwanis Club on Tuesday, February 9, was featured by talks given by two local physicians. *Dr. Phillip M. Kauth* spoke on "The Common Cold." *Dr. H. Meyer Lynch*, speaking very briefly on "Social Diseases," confined his remarks almost exclusively to the prevalence of these diseases in our army camps.

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The annual meeting of the American Association of Pathologists and Bacteriologists, scheduled to be held at the University of Chicago, April 1 and 2, has been cancelled because of present limitations upon travel and hotel accomodations. The Council of the Association will meet early in April to transact the necessary business of the Association.

Nominations for membership, together with supporting data and not less than two letters of recommendation, should be in the Secretary's office not later than April 1, 1943.

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Dr. George M. Shinners, Green Bay, spoke February 2 at the first meeting of the new health committee of the Association of Commerce. This committee is making a survey of the health department activities in the city in the last year. The survey is to be entered in the national intercity health conservation contest sponsored by the American Public Health Association.

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The Milwaukee Oto-Ophthalmic Society held their meeting Tuesday, February 9, at the University Club. "Influence of Vestibular Stimulation on the Fusion Frequency of Flicker in Normal Subjects and in Patients with the Post-Concussion Syndrome" was given by *Dr. Meyer Fox*, and a discussion was conducted by *Dr. Norbert Enzer*. *Dr. Herbert Schmidt* showed motion pictures of Mexico.

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The staff of St. Francis Hospital, La Crosse, met Monday evening, February 8, at the St. Francis School of Nursing auditorium. Dr. Milton Levine, Chicago, spoke on "The Necessity and Utility of Establishing a Blood Bank in a Community."

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Dr. Robert E. Burns, professor of orthopedic surgery at the University of Wisconsin Medical School, spoke on "Backache" at the staff meeting of the Wisconsin General Hospital, Tuesday, January 26.

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A child guidance clinic is being held in the Twin Cities this year. The clinic is to be in the nature of psychiatric consultations with children up to eighteen years of age. Similar clinics are to be established in Oshkosh.

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Drs. William E. Grove and *Jasper M. Molsberry* were the two speakers at the December 8 meeting of the Milwaukee Oto-Ophthalmic Society held at the University Club.

—△—

On Tuesday, January 12, *Dr. Samuel S. Blankstein* spoke on "Kuhnt-Junius Degeneration of Macula in Child Age Nine" at the Milwaukee Oto-Ophthalmic Society. "Treatment of Chronic Stenosis of Larynx," discussed by Dr. L. R. Marshall, was the second topic of the meeting.

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The Fifth Annual Congress on Industrial Health, sponsored by The Council on Industrial Health of the American Medical Association, was held at the Palmer House, Chicago, January 11–13.

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Dr. Irvine H. Page, director of the Indianapolis City Hospital, spoke on "The Nature of Experimental and Clinical Hypertension" at the Alpha Omega Alpha meeting January 21 at the Service Memorial Institute, Madison.

—△—

The meeting of the American Foundation for Tropical Medicine Inc., was held on Tuesday, January 19, at the University Club in New York City. The Foundation is an agency through which individuals and business concerns with interests in tropical areas can aid in strengthening facilities in this

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**Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154*
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
Proc. Soc. Exp. Biol. and Med., 1934, 32, 241
N. Y. State Journ. Med., Vol. 35, 6-1-35, No. 11, 590-592.

country for study and research in tropical diseases. The membership meeting approved plans submitted by the Executive Committee to secure $100,000 in gifts to provide for expansion of activities in the current year.

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Dr. Harold M. Coon, superintendent of the Wisconsin General Hospital, Madison, was elected president of the Wisconsin Hospital Association. This meeting and election of officers was held in Milwaukee, January 22.

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Dr. Roll O. Grigsby was named president of the staff of officers of St. Joseph's Hospital, Ashland. Vice-president is *Dr. Andre H. Lamal,* while *Dr. Kenneth A. Siefert* is the secretary.

—△—

Mrs. G. E. Stoddart, Beaver Dam, has been named regional deputy commander of the American Society for the Control of Cancer. This territory embraces the states of Wisconsin, Michigan, Illinois, Iowa, Minnesota, South Dakota, Kansas, Nebraska, and Missouri. Since 1939, Mrs. Stoddart has been commander of the Women's Field Army of the American Society for the Control of Cancer and, for the past five years, editor of the Wisconsin Field Army's bulletin.

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Dr. Albert J. Gloss, Appleton, recently completed a two months' postgraduate course in surgery at Chicago.

—△—

At the commencement exercises of the Marquette University School of Medicine on February 13, Rear Admiral Ross T. McIntire, Surgeon General of the United States Navy and personal physician to President Roosevelt, gave the convocation address and had conferred upon him the degree of Doctor of Science (honoris causa).

As a result of the accelerated program in medical education and the abolishment, for the duration of the War, of the requirement of the internship for the degree of Doctor of Medicine, two classes of 150 students were graduated at this time.

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Because the Government has again discouraged the holding of medical conventions, except those primarily of military interest, plans for the June meeting of the American Urological Association in St. Louis have been cancelled.

The Association announces that this year it will not award the $500 research prize which it customarily offers annually.

—△—

The regular staff meeting of the Wisconsin General Hospital was held Tuesday, February 23, at 7:45 p. m. *Dr. Ira R. Sisk,* Professor of Urology at the University of Wisconsin Medical School, discussed "The Etiology and Treatment of Renal and Ureteral Stones."

—△—

The seventeenth annual meeting of the National Conference on Medical Service was held at the Palmer House, Chicago, on Sunday, February 14. *Dr. Eben J. Carey,* Dean of Marquette University School of Medicine, Milwaukee, was one of several speakers at the morning session. The central topic of the morning session was "Analysis of Current Trends in the Control of Medicine." Dr. Carey spoke on the "Effect on Medical Education." "Medicine in the Post-War Era" was the basis for the afternoon speeches and discussion.

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Attended by representatives of the Council on Medical Education and Hospitals, the Federation of State Medical Boards, and the Central Council for Nursing Education, the Thirty-Ninth Annual Congress on Medical Education and Licensure was held February 15 and 16 at the Palmer House, Chicago. Discussion during the two days' meeting centered upon the relationship between the war emergency and medical education, civilian medical needs, health resources, and medical licensure. Presiding at the Monday session was Dr. Ray Lyman Wilbur, Stanford University, California, Chairman of the Council on Medical Education and Hospitals; at the Tuesday session, Dr. Julian F. Du Bois, St. Paul, Secretary of the Minnesota State Board of Medical Examiners.

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Sponsored by the American College of Surgeons, a War Session for physicians and hospital representatives of Wisconsin and Illinois was held at the Hotel Schroeder, Milwaukee, on Wednesday, March 3, from 9:00 a. m. to 10:00 p. m. This was one of a series of twenty one-day meetings being held between March 1 and March 20 with every state, the District of Columbia, and the provinces of Ontario and British Columbia participating. The opening meeting was devoted to a discussion of medical and surgical aspects of chemical warfare, led by a representative of the United States Office of Civilian Defense. The closing meeting was a panel discussion on problems in wartime civilian medical practice led by representatives of the United States Public Health Service.

Dr. Irvin Abell, Chairman of the Board of Regents of the College, emphasizes that, although participating states and provinces for each meeting have been designated to facilitate arrangements, there will be no geographic restriction on attendance, and those who plan to attend may select the place and time which are most convenient. It can thereby be concluded that if you missed this important meeting in Milwaukee, it will be possible for you to attend a similar meeting in a nearby state.

The American College of Surgeons cancelled its 1942 national meeting and is holding in abeyance plans for a Clinical Congress in 1943. In the meantime, it is offering the regional meeting plan provided by the War Sessions to save the time of the doctors and other personnel and to minimize transportation difficulties without sacrificing unduly during wartime the educational and stimulative benefits of medical assemblies.

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BIRTHS

A son, Craig Russell, to Dr. and Mrs. Russell Johnston, La Crosse, on November 30.

A daughter, Patricia Mary, to Dr. and Mrs. Myron T. McCormack, Milwaukee, on February 7.

DEATHS

DR. THOMAS J. O'LEARY

Dr. Thomas J. O'Leary, 61, Superior, died suddenly on February 26 following a brief illness, thus bringing to a close a thirty-five year career of medical practice.

Dr. O'Leary was born in 1881 at Wabasha, Minnesota. He attended the parochial and public schools at Wabasha and received his degree of M. D. at the College of Physicians and Surgeons at the University of Illinois in 1906. He served his internship at St. Mary's Hospital in Superior in 1906–07 and began general practice in Superior following internship. He was chief of staff at St. Joseph's Hospital, Superior, and formerly chief of staff at both St. Mary's and St. Francis'.

Since 1915 his practice had been devoted to surgery. At the time of his death he was the local surgeon for the Soo Line Railroad, a position he had held for many years.

He was a past-president of the Douglas County Medical Society, the Interurban Academy of Medicine, the Eleventh District Medical Society and a Fellow of the American College of Surgeons. He was president of the State Medical Society in 1934–35 and, at the time of his death, was Councilor from the Eleventh District of the State Medical Society and chairman of the Society's Conference Committee on Open Panels.

He is survived by his widow, Alice, and two daughters, Mrs. Thomas J. Doyle of Superior, and Mrs. Brandon E. Crawford, Richmond, Virginia. Also surviving are one grandchild and a sister, Miss Abigail O'Leary, Minneapolis.

The following appeared in the editorial columns of the Superior *Evening Telegram*, February 27:

"It is always with a keen sense of loss that the people of a community mark the passing of a physician whose life has been spent among them. The loss is especially felt when it takes one whose professional and civic activity were continued almost until the last day. This was true of Dr. T. J. O'Leary, whose death occurred Friday. His going takes one whose professional skill won him position among the leading surgeons of the state and who as a citizen had identified him closely with the life of the community in many ways.

"But eminence as a surgeon did not cause Doctor O'Leary to devote himself to surgery to the exclusion of his work among the people to whom he had been so long a trusted family physician. He insisted in giving himself just as fully to the more confining routine in spite of the heavy draft on his time and energy, which no doubt left him less able to cope with the ailment that caused his death.

"Superior has long been fortunate in the type of men who have chosen this city as the scene of their labors in the medical field. In just a short time the people here have been called upon to mourn the death of several, all of whom had seemed indispensable to their home city. First there were the long-beloved Doctors P. G. McGill and John Baird and more recently Dr. J. C. Sarazin and now Dr. T. J. O'Leary. To lose the service and the citizenship of four such men in so brief a period seems an exceptional bereavement yet they have left a record in service of which the city may well take pride and for which be grateful."

Dr. Marlin C. Crane, 66, physician and surgeon of Wittenberg, died February 17 following several years of failing health.

He was a graduate of Rush Medical College and Milwaukee Medical College. For his work at Yokohama harbor during the great Japanese earthquake in September, 1923, when he was in the ship medical service of a Dutch boat line, he received a medal from the Holland mercantile marine, a silver medal from the Queen of Holland, and a loving cup from the persons he assisted. He returned to the United States in 1924. Since November, 1938, he had practiced at Wittenberg.

At the time of his death, Dr. Crane was a member of the Shawano County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by two sons and a sister.

Dr. John B. Gordon, 70, died suddenly in Chicago on Tuesday, January 26. He had been a physician in Shawano nearly forty years.

Following graduation from Ohio Wesleyan College, Dr. Gordon taught school for a few years. Realizing an ambition to study medicine, he entered Rush Medical College, from which he was graduated in 1903.

Survivors include his widow, one brother, and two sisters.

COMING EVENTS

University of Illinois College of Medicine Refresher Course in Laryngology, Rhinology and Otology
March 22 to 27, 1943

To meet the needs of ear, nose and throat specialists who, under existing conditions, are able to devote only a brief period to postgraduate review study, this didactic and clinical course has been arranged. Registration is limited.

Application letters for registration must include the name of the school from which the applicant was graduated, year of graduation, and details concerning specialty training and experience. The registration fee is $50.

For further information and application blanks, address Department of Oto-Laryngology, University of Illinois College of Medicine, 1853 West Polk Street, Chicago, Illinois.

American Public Health Association

The Executive Board of the American Public Health Association announces that the Association will sponsor a three day Wartime Public Health Conference in New York City, October 12, 13 and 14. The seventy-second annual business meeting of the Association will be held in connection with it. The Conference program will be devoted exclusively to wartime emergency problems as they affect public health and the public health profession.

West Virginia State Medical Association

The seventy-sixth annual meeting of the West Virginia State Medical Association will be held at the Daniel Boone Hotel, Charleston, May 17 and 18. The preconvention meeting of the Council will be held Sunday evening, May 16, and will be followed by the first session of the House of Delegates. The second session will convene the following day. Full scientific programs will be presented during the two-day meeting.

Wisconsin General Hospital Staff Meetings for 1943

These meetings are held in the Auditorium of the Service Memorial Institute. They are open to third and fourth year medical students, interns, residents, hospital and medical school faculty, and interested outside physicians.

March 16—Dr. J. E. Gonce: Some Aspects of Urinary Infection in Infancy and Childhood
March 23—Dr. C. S. Harper: Office Gynecology
April 6—Dr. R. E. Campbell: Carcinoma of the Uterus
April 20—Dr. K. L. Puestow: Sigmoidoscopic and Radiologic Correlation in Diagnosis and Treatment of Colonic Disorders
May 4—Dr. E. A. Pohle: Indications and Contraindications for Roentgen Therapy
May 18—Dr. L. W. Paul: Fundamentals of Gastro-Intestinal X-Ray Diagnosis

SOCIETY RECORDS

New Members

T. S. Rosen, Eau Claire.
R. B. Smith, Madison.
Jackman Pyre, Fort Custer.
A. D. Baird, Montreal.
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Changes in Address

O. H. Coontz, Madison, to Pascagonia, Mississippi.

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D. A. R. Morrison, Oconomowoc, to 4454 North Woodburn Street, Shorewood.

TRADE NEWS

New Squibb Capsules Supply Massive Doses of Vitamin D

To provide massive doses of vitamin D for use in the treatment of hypoparathyroid tetany and certain types of rickets, E. R. Squibb & Sons, New York, are now supplying capsules of Viosterol, each containing 50,000 U. S. P. units of vitamin D_2. The capsules are packaged in bottles of forty and 100.

Clinically, vitamin D may be used to produce either of two effects, depending upon the dosage. In relatively low dosage, it exerts antirachitic activity, while in high dosage, ranging upward from 60,000 units daily, it raises a subnormal serum calcium level and is therefore useful in hypoparathyroid tetany. It is also sometimes administered as a single massive dose in the treatment of active rickets.

In hypoparathyroid tetany, an initial dose of eight or more Squibb Vitamin D Capsules daily is suggested, and a maintenance dose of two to four daily. In obstinate rickets, one capsule daily is recommended; in refractory rickets, one or more capsules daily; and in thoracic rickets, one capsule daily for two or three weeks.

In addition to the new Vitamin D Capsules, Squibb, of course, will continue to supply Viosterol in Oil, one gram of which contains the equivalent of 10,000 U. S. P. XII units of vitamin D.

—△—

Postoperative Vitamin Deficiencies

Prolonged chronic illness followed by sharp limitation of diet during a period of preoperative preparation, especially when surgery of the gastrointestinal tract is contemplated, may result in a state of partial vitamin depletion. Most parenteral fluids routinely contain glucose, which sets up an additional drain on the vitamin B stores in the body. Postoperatively, nausea and vomiting occur frequently, and there is often the necessity for complete restriction of food for days at a time.

This sequence of events was clearly reproduced in a case recently reported (Ann. Int. Med., 18:110, 1943). The patient developed a sore tongue and became uncooperative, disoriented, and confused. A dramatic change ensued after administration of riboflavin and nicotinic acid, with complete disappearance of the lesions within five days.

A number of laboratory procedures have been developed in recent years to augment the clinical diagnostic approach to vitamin deficiency disease, but many of them require special equipment and are not easily adaptable for routine clinical use. Physicians may obtain a list of vitamin values of foods and a bibliography of important and generally informative papers on vitamins by writing Eli Lilly and Company, Indianapolis.

—△—

Winthrop Chemical Announces Election

Election of B. Thurber Guild, M. D., member of the staff of the Massachusetts General Hospital, Boston, as president of Fairchild Brothers and Foster, a subsidiary of Winthrop Chemical Company, has been announced by Dr. Theodore G. Klumpp, president of the parent company.

Fairchild Brothers and Foster manufacture enzymes and other ethical pharmaceutical products.

Since 1920, Dr. Guild has specialized in internal medicine and the study and treatment of diseases due to allergy; and he has maintained a consultant practice in problems of dermatology complicated by allergy. He is a past-president of the Dorchester Medical Society, consultant of the Council on Pharmacy and Chemistry of the American Medical Association, and counsellor of the Massachusetts Medical Society. He is a member of the Society for Investigative Dermatology and the Society for the Study of Asthma and Allied Conditions, and is secretary of the Boston Allergy Round Table.

Dr. Guild's researches include a study of skin diseases of small animals conducted at the Angell Animal Hospital, Boston, and of problems of human skin irritations due to soap.

—△—

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WANTED—One or two additional specialists to share an excellently equipped and furnished suite in a Milwaukee downtown office building. Secretarial, x-ray, and laboratory facilities provided. Address replies to No. 59 in care of Journal.

LOCUM TENENS: Doctor, with wide experience in general practice and surgery, desires to do locum tenens anywhere in Wisconsin or will accept position for duration. Draft exempt. Good personality, character and training. Address replies to No. 67 in care of Journal.

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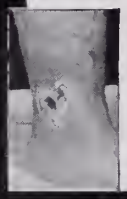

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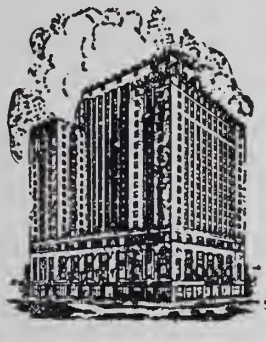

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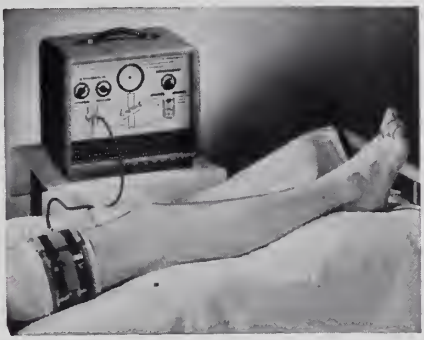

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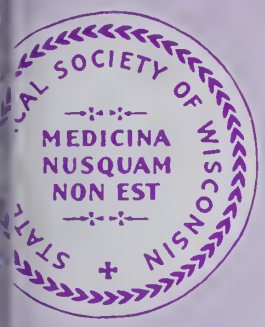

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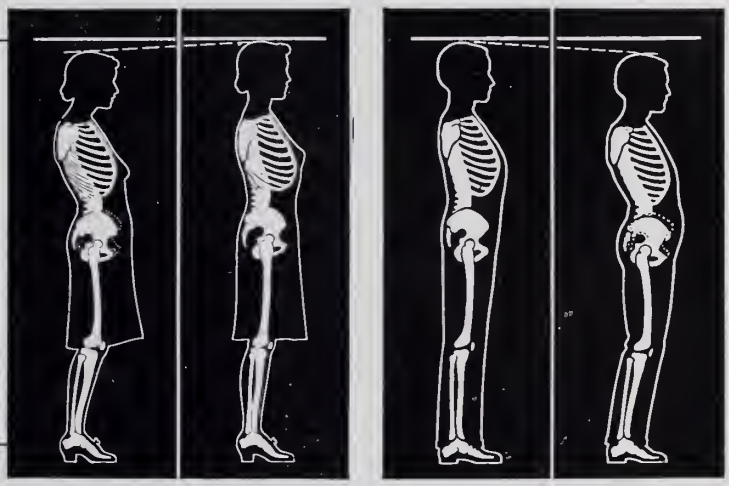

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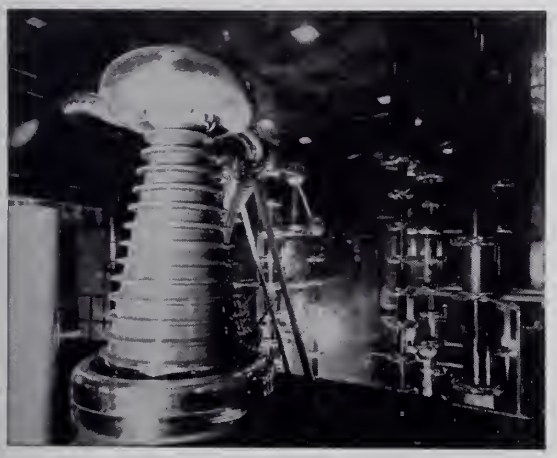

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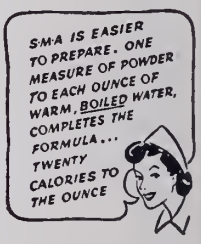

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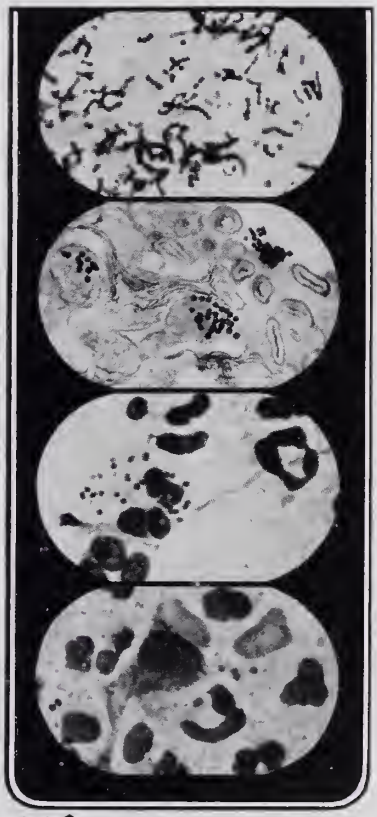

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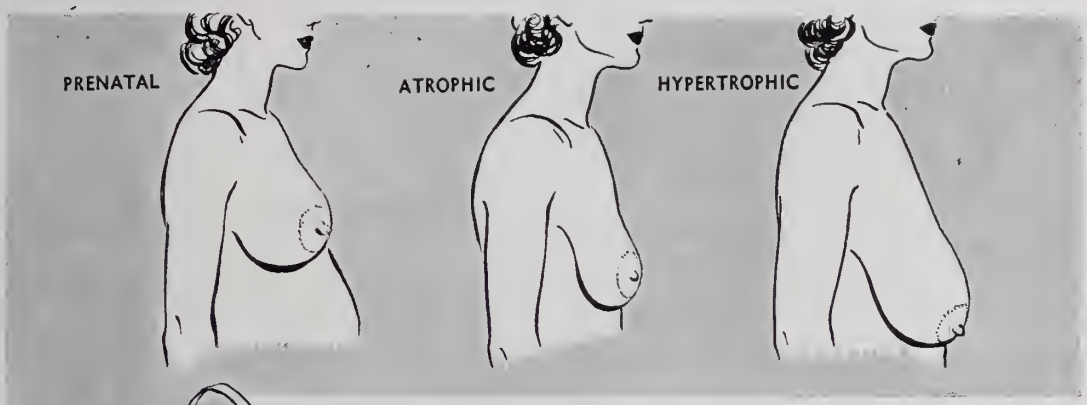

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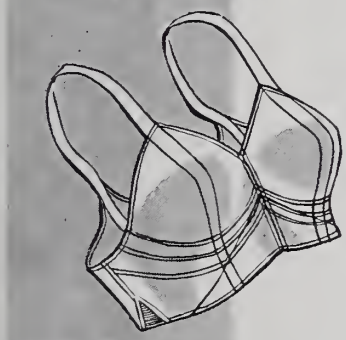
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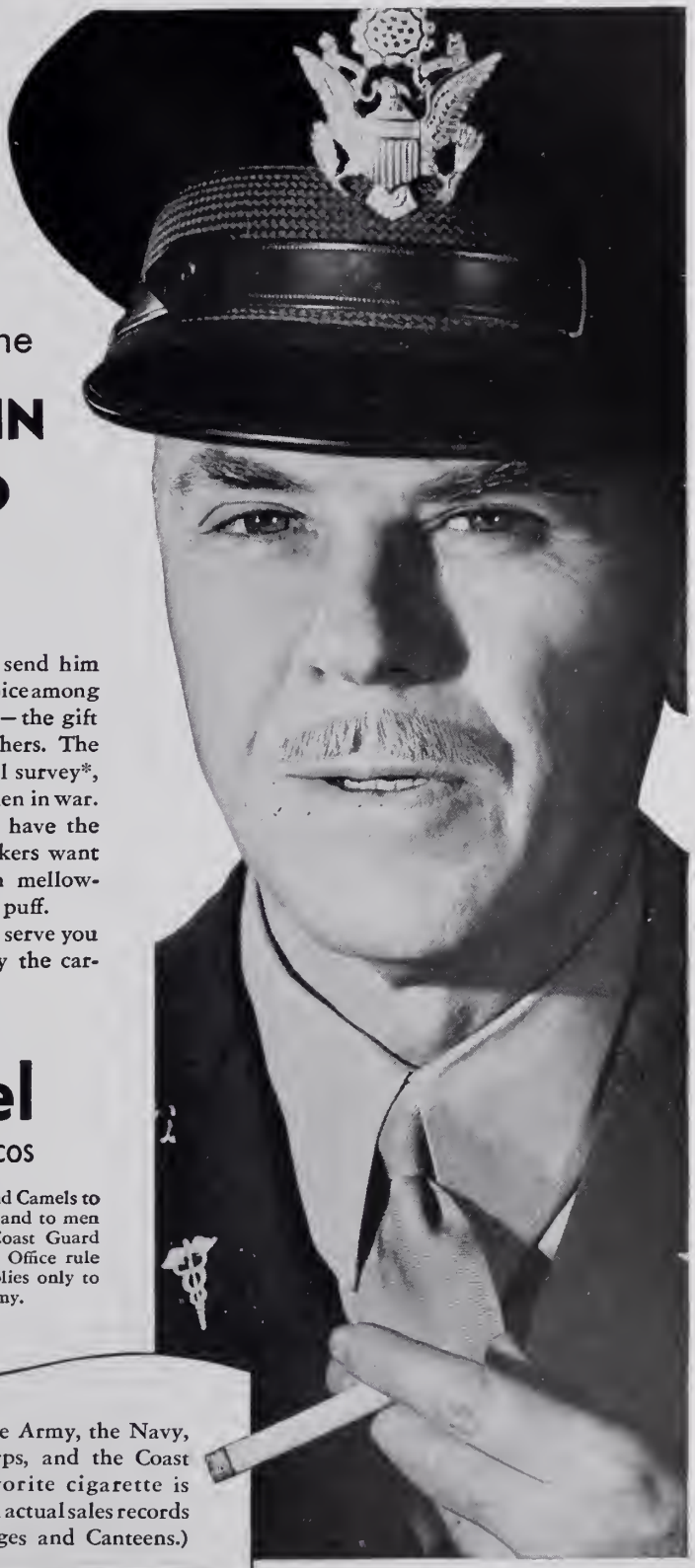

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Low Back Pain*

Anatomic and Constitutional Aspects in the Differential Diagnosis

By HARRY E. MOCK, M. D.
Chicago

H. E. MOCK

LOW back pain is one of the oldest and most common ailments of suffering humanity. It has been a lucrative field for cultists and the medical profession alike. Because of its medicolegal potentialities, it has been especially lucrative to the legal profession.

Prior to the days of roentgenology, and especially prior to the days of specialization, "guess work" was the chief diagnostic method. Thus, torn muscles in the back, subluxation of certain vertebrae, lumbago, and similar diagnoses were the rule. Without question, the ailment was just as common at the time of the Civil War and the remaining decades of the last century as now; yet, as a disease entity, it occupied very little space in our earlier medical literature. If its ravages had been as devastating as many other diseases, or if thousands of workers annually had been permanently disabled thereby, it stands to reason that the older authorities would have devoted far more attention to the condition.

Today we are forced to wonder how the preceding generations survived their painful backs, how they carried on the strenuous activities of the premachine age, and how they made this the greatest of all industrial nations without the benefit of our modern medical and surgical methods of alleviating low back pain.

Railroad Spine

With the advent of railroads and the development of increasingly larger adjustments for railroad injuries, "railroad spine" received the chief attention of the older surgeons. Then, just as today, there were many serious fractures and dislocations of the spine which resulted in permanent disability or death. Then, just as today, there were numerous jerking, twisting and straining injuries which gave a bizarre pattern of symptoms and were diagnosed as "railroad spines." Great settlements were paid, and the majority of these cases then recovered.

With the advent of the roentgen ray, we realized that many of these had had compression fractures, partial dislocations, or other evidence of bony trauma or disease which had made their claims for disability legitimate. Likewise, it was evident that many who had never made claims suffered similar injuries. The point is that practically all of these recovered and continued to function as useful citizens. How many of these were herniated discs, and how much surgery was lost by these old surgeons? How much suffering would have been alleviated if we had known then what we know now? These are questions which future generations must answer.

Trauma A Common Etiologic Explanation

Since the beginning of this century, the etiologic explanation and the diagnosis of the lesion present in low back pain have de-

* Presented before the Postgraduate Industrial Medical and Surgical Clinic of the State Medical Society of Wisconsin, Milwaukee, November, 1942.

pended too often upon guess work, acceptance of the most obvious cause, a cause usually advanced by the patient, or a tendency to locate the lesion in the field of one's own specialty. With the creation of employees' compensation laws in the majority of the states in the early part of this century, trauma became the most common etiologic explanation for the low back pain. The surgeons who jumped to the conclusion that an alleged injury was responsible for the condition usually fitted their diagnosis to dovetail with the etiology. Thus sprained back and torn muscles, the result of overlifting or a straining, jerking movement, continued to be common diagnoses. As the years went by, and as roentgenographic technic became more and more refined, these diagnoses were supplanted by strained sacroiliac joint, slipping sacroiliac joint, lumbosacral strain, slipped vertebra, or spondylolisthesis and similar anatomic conjectures. Today these diagnoses are far less frequent. The changing styles in back diagnoses have brought into prominence a new condition commonly ascribed to injury and variously called nucleus pulposus derangement, herniated disc, or thickened ligamenta flava.

Nuclear Changes

Nuclear changes are common in many spines and are seldom, if ever, related to a specific injury. Thickened ligamenta flava undoubtedly could be found in the majority of backs subjected to the wear and tear of heavy labor. It is difficult to conceive of a specific injury causing such a thickening. A true herniated disc might follow a specific injury. However, the histories of so many cases in which herniated discs have been found indicate that the attacks of back pain have been recurrent and have covered a long period, and that the etiologic factor is very indefinite when the pain is ascribed to injury. Nuclear changes are rarely, if ever, found in a truly seriously injured back. When we consider the irregularities within the spinal canal that must project or press against the cord following some of these serious injuries, it makes us wonder at the havoc the projecting disc seems to cause. Is it not possible that many of us may have herniated discs due to natural wear and tear? This and similar questions deserve study and investigation before one decides that the majority of herniated discs are the result of injury. That herniated discs are a factor in causing back pain and sciatica is no longer open to dispute, if we consider the number of patients who have been relieved by the operative removal of the discs. We must not forget, however, the great number of painful backs which the medical profession failed to relieve in the past, with the patients turning to osteopathy and claiming to be cured after these treatments. The fact that certain low back pains respond to osteopathy and others to operative removal of a herniated disc does not solve all the mysteries surrounding this complicated anatomic region.

The Stiller Type

With these changing styles in diagnosis, many new styles of treatment have come and gone. Three or four decades ago, gynecology claimed many of these low back victims. Displacements of the uterus, pus tubes, and similar pelvic conditions were thought to be the chief causes of low back pain in women. Suspensions of the uterus and the removal of acute and chronic pus tubes became the vogue. Starting as a gynecologist and practicing that specialty for seven years, the author knows from experience how common this practice was. Today, both operations are exceedingly rare among the best gynecologists. Similarly, operations for fixation of the floating kidney or for ptosis of the stomach have come and gone. It is interesting to note that the individuals who usually had these conditions were of the Stiller type, the neurocirculatory asthenic individual of the present time, and that many of the sufferers from chronic low back pain who today are having their backs operated upon are likewise of the Stiller type.

Prior to the first World War, the specialty of orthopedic surgery recognized faulty posture as the cause of many of these low back conditions, and corrective exercises resulted in many cures. Many patients, however, lost the benefit of these corrective exercises by having their backs immobilized in some kind

of a back brace. It was during this period that sacroiliac sprain became the most frequent diagnosis, made too often without a thorough investigation of the entire body, and the immediate application of a sacroiliac belt was the rule. This facile ordering of sacroiliac belts, and other types of back braces or corsets, was not limited to the orthopedic specialty, but the majority of the profession, regardless of specialty, accepted this diagnosis and persisted in ordering belts.

Fusion Operations

Since the first World War, the orthopedist has become more of an operative surgeon. The low back pain, still ascribed to trauma, has been diagnosed as a commonly overlooked fractured lamina, or the spondylolisthesis shown by the roentgenogram has just occurred as a result of the alleged trauma or, if pre-existing, has been aggravated by that trauma. Fusion of the spine became the treatment of choice. There was a period when many treated compression fractures of the spine by a fusion operation. Rarely is it performed today for this condition. This fact does not condemn the fusion operation, an operation so definitely indicated in certain conditions.

Physical Therapy

Physical therapy has become an outstanding specialty since the first World War. Many are the low back conditions that are treated, often beneficially, by physical therapy. To be successful, this method must include a thorough study of the entire body as well as the back. Disease or injury of the spinal column or the cord must be ruled out, or at least one must be positive that a local condition, if present, is adaptable to physical therapy. When the condition is due to some constitutional disease, to continue to treat an individual with low back pain by physical therapy is erroneous management. But when a thorough course of heat, massage and corrective exercises for faulty posture is indicated, to continue to treat a low back pain by only short wave, diathermy, or a heat lamp is to be condemned.

Literally thousands of employed patients suffer a sudden pain in their low back while lifting an object, a maneuver they have performed daily for years without any trouble. Thousands of these patients are referred to the doctors in charge of the plants. Many of these doctors accept the patient's statement that he strained his back while lifting and, without making a complete examination, turn the patient over to a nurse for short wave or heat treatment. Many other patients receive a "shot" to relieve the pain. The fact that they are treated by the company doctor as an injury case fixes the idea of trauma and compensation. Many other pateints in this category are referred to the plant nurse, who likewise accepts the traumatic etiology and gives heat treatment or tapes the back. Such treatment is a form of machine therapy and should not be classified or thought of as true physical therapy. The etiologic factor of injury is not correct in the majority of instances, but the fact that the theory of injury was accepted and treatment instituted usually makes the company or its insurance carrier responsible.

Neurosurgery

In recent years, neurosurgery has come into this field of low back pain. Ruptured or herniated intervertebral disc is becoming one of the most common diagnoses for low back pain, especially if sciatica is present. Whether the removal of the offending disc belongs in the field of neurosurgery or orthopedic surgery is a mooted question. The neurosurgeon rarely fuses the spine following the operation on the disc, while many orthopedic surgeons feel that fusion is a definite part of the operation. The operation is not limited to these specialties because numerous operations for nuclear or disc derangements are being recommended by general surgeons and are often performed by them. It is becoming one of the most common surgical operations. Subtemporal decompression in head injuries once swept the country and then was discarded, although in carefully selected cases and when performed at the right time, it is still indicated. Must this be the history of partial laminectomies in herniated discs?

Dandy states:[1] "Ruptured intervertebral discs are now known to be exceedingly common; they are, in fact, among the most frequent lesions treated surgically. Over 95 per cent of them are in the lumbar region, where they explain the overwhelming percentage of recurring pains low in the back plus sciatica in one or both legs."

Dandy states[2] in another article: "The history of trauma, which is always the cause may be difficult to elicit and need not be obtained. The injury is usually a minor one, such as a heavy lift, a wrench or a sudden movement. I can't recall having seen a protruding disc after a severe back injury." He further states: "The history of recurring pain is essential to the diagnosis and in the differential diagnosis from psychogenic backaches, which are always present."

In his September, 1941, article, Dandy prepares the way for his later article which condemns the use of iodized oil injections for diagnostic purposes except in certain exceptional cases. He states:[2] "How can the diagnosis of a ruptured vertebral disc at the fourth and fifth lumbar interspaces be made with assurance? The diagnosis is made on low midline backache plus pain down the back of one or both legs, the pain is intensified by coughing and sneezing, and the pain must be recurring and not continuous. When this simple story is obtained there is no other lesion that need be considered. There may or may not be diminution of the achilles reflex or sensory or motor loss in the distribution of the fourth or fifth lumbar or first sacral nerve." Many surgeons who do not have the facilities of a great clinic behind them for a complete, thorough study of the individual before he is selected as a neurosurgical case take these statements at face value. We have an ever increasing number of patients to whom this operation was recommended on no more evidence than the above, but in whom a thorough study of the entire body revealed other causes that could explain the low back pain.

In another place in this article,[2] Dandy states: "Love, who has done so much to develop this field of surgery, has had over 1,000 cases. There are, of course, many cases of constant pain that are not due to vertebral discs, and most of them are of psychogenic origin; they will fail to give exacerbation of pain on coughing or sneezing—a sign that I regard as pathognomonic of a disc or possibly a tumor."

Concerning his results, Dandy mentions that he has had perhaps 300 cases with only three bad results, two of these due to the location of the ruptured disc in the cervical and dorsal region with permanent injury to the cord, and the third in the lumbar region due to delay in diagnosis and treatment. Considering the widespread distribution of this operation, the bad results are bound to be greater. From the injury and compensation standpoint, the fact that insurance companies dread and fear the diagnosis and operation indicates that it is not always successful or economically sound.

Anyone who has had lumbago, or even a twinge of sciatica, knows that sneezing causes pain. Duncan and Hoen[3] stress this fact and do not consider sneezing a pathognomonic sign. In approximately 20 patients seen in the last six months and diagnosed elsewhere as having a possibly ruptured intervertebral disc, each patient, when his history was secured, has mentioned that sneezing had caused pain. On further questioning, one learns that the doctor who saw the patient previously had asked this question. Has the profession accepted the conclusion that this is a pathognomonic sign?

In his last article, Dandy urges using every diagnostic method except the injection of iodized oil or air. He feels that only in exceptional cases are these necessary procedures. He stresses the medicolegal effects of iodized oil in the spinal column. This procedure certainly has its medicolegal hazards.

Schmorl's Work

Schmorl, of Dresden, did a monumental piece of work when he studied 7,000 consecutive spines at routine autopsies. He described the rupture or herniation of a nucleus pulposus as occurring in 15 per cent of the spines studied. Nowhere in his writings did he claim that these protrusions were due to specific trauma, were always responsible for symptoms or that they required surgery. Ormond Beadle,[4] who spent two

years in Dresden and reviewed Schmorl's work, is chiefly responsible for our modern conception of the intervertebral disc. Beadle states: "The spine is perhaps more than any other part exposed to the daily wear and tear of functional activity and owing to the peculiar conditions this functional trauma, never in abeyance, can continue to work the most far reaching damage to its structure without causing any noticeable disability. It is for this reason that diseases of the spine often seem so inexplicable; that the examination of large numbers of supposedly healthy spines teach this point of view as its chief lesson." This author then describes hundreds of spines with all manner of degenerative and proliferative changes in patients with supposedly healthy spines. Certain of these had protrusions into the neurocanal, and yet the histories of these patients indicated absence of back symptoms.

From a study of Schmorl's work, it is evident that he never intended to give the impression that these conditions were due to one definite trauma or that they immediately follow definite trauma. He referred to functional trauma, or the wear and tear on the spine, as the result of normal daily activity. In contradistinction to this, Love states that in 32 per cent of 100 cases, immediate trauma was given as the cause. As stated previously, Dandy affirms that trauma, minor trauma, is always the cause.

Conservatism Necessary

As scientific research increases the storehouse of knowledge, it is natural that our old conceptions of pathology, the cause thereof, and the method of attack should change. Some of these changes are fundamental and lasting; others are accepted with enthusiasm, given a trial, and later discarded. These latter can be depicted as changing styles in surgery which, if too quickly accepted and too suddenly dropped, discredit surgery. To avoid such disparagement is the only excuse an author can advance for dwelling upon the styles that have come and gone in the diagnosis and treatment of low back pain.

Unquestionably, there are pelvic conditions, even displacements of the uterus, which are responsible for the low back pain in certain patients. In these cases, pelvic operations are justifiable. However, the gynecologists have taught conservatism to the profession to the point that suspension of the uterus and other pelvic operations for the relief of low back pain are rare procedures today as compared to the past.

Unquestionably, there is the occasional case with floating kidney which gives such a severe Dietl's crisis that a fixation operation is absolutely necessary. However, the profession has long since learned that floating kidneys, as well as general enteroptosis, are normal anatomic conditions in the Stiller type—the long-waisted, narrow-intercostal-angled individual. Such individuals are flat-backed and are prone to have faulty posture with its accompanying backache. Years ago we learned the futility of operating floating kidneys to relieve backache in this type of patient. Such operations are a rarity today.

Unquestionably, there are cases of strained or sprained backs which are made more comfortable and are able to continue their work because of a back brace or sacroiliac belt. Those who have become wedded to such an apparatus consider the surgeon crazy who decries its use. Those of us who criticize its use feel that overcoming faulty posture and restoring muscle and ligamentum stability and function is far wiser than to allow the patient to become dependent upon a crutch. The back brace applied to a patient with a compression fracture and worn for months, as is so often the case, delays restoration of function and too often enhances the seriousness of the case in the patient's mind. Just as a pair of crutches signifies a cripple, so does the back brace signify continued disability. Too often it becomes a useful weapon for the plaintiff's lawyer. While we recognize the value of back braces, corsets and belts for temporary relief, yet the prescribing of them for prolonged use in a chronic case is rapidly disappearing.

Unquestionably, there are cases in which fusion of the arches of the lower lumbar vertebrae has failed, cases of definite spondylolisthesis which resist all conservative methods of treatment and can be cured only by a fusion operation. There are several other

conditions that require fusion operations. But it is poor judgment to jump to the conclusion that the roentgenographic evidence of a spondylolisthesis or some other bony anomaly in the spine or sacroiliac joints proves that such a condition is responsible for the low back pain and therefore must be combated by a fusion operation. Before one turns to radical operation, every such case demands the most painstaking study to rule out other causes and weeks or months of conservative treatment. Fusion operations are a godsend, but the patient requiring such procedure must be selected most carefully.

Cases of Ruptured and Herniated Discs

Unquestionably, there are cases of ruptured and herniated discs. According to Schmorl, 15 per cent of us have some such derangement. This condition, although recently discovered, must have existed since the human race evolved. Unquestionably, certain of these protrusions have so damaged the cord or nerve roots that years of suffering and occasional permanent paralysis have ensued. Yet any man who has been in practice for thirty years must agree that the number of such cases of permanent or total disability has been exceedingly rare. We have all seen patients who have had recurrent attacks of low back pain and severe sciatica who undoubtedly would have been saved much suffering if an exploration of their lower spines had been done. Again, the number of these cases in the past has not been great. The majority of our patients with low back pains have yielded to conservative treatment. There were many psychogenic individuals who were relieved of their complaints by a fixation of the floating kidney. There are many individuals who have three or four scars on their abdomens. These multiple operations too often were in the psychogenic individual. We must guard carefully lest we add another scar to such individuals, this time on the back.

This great advance in surgery, the operation for a ruptured or herniated intervertebral disc, is still in its infancy. It should learn to walk and grow into full manhood before it is overworked and dies from weakness. It is too young to be classified as the "most frequent lesion treated surgically." Whereas two years ago most surgeons who were absolutely sold on this operation stated that it should be limited to those patients who failed to respond to a thorough course of conservative treatment, yet today some of these same surgeons are diagnosing the condition in a fifteen to twenty minute examination, are recommending immediate operation without even roentgen-ray study or a complete physical examination, are saying that the sneeze-pain reflex is pathognomonic, and are telling the patients that they will be completely cured after ten days in the hospital and ten days of convalescence. I still contend that those patients who give very definite neurologic findings, whose conditions are difficult to differentiate from cord tumors, or who have failed to yield to the most expert comprehensive physical therapy treatment are bonafide candidates for thorough exploration of the spine and cord at the site indicated. No question can be raised concerning those rare cases that develop a sudden paresis or paralysis in the cervical or dorsal regions, as described by Dandy. In these, immediate surgery definitely is indicated. But our enthusiasm for this operation should not cause us to recommend it for patients with low midline backache plus pain down the back of one or both legs and with the pain intensified by coughing and sneezing, regardless of whether the pain is recurring or continuous. There are too many anatomic and constitutional conditions which can cause exactly this same chain of symptoms and which will continue to exist even after the patient has been subjected to this operation. It is this euthusiasm and this facile choosing of the cases for operation which will eventually discredit it. It is too valuable a procedure, when indicated, to be discredited.

Complications Following Operation

Finally, the ease of diagnosis which is being taught and the apparent simplicity of the operation is causing many a surgeon, not qualified in judgment or technic, to operate his series of cases. In the hands of very competent men, complications are rare; in the hands of the less competent, complications

are bound to increase. Already we have studied one case that received a settlement of $18,000 because of the persistence of iodized oil in the spinal column even after an effort to wash it out had been made. We have seen one case of persistent low back pain after the operation for a herniated disc in which the pain and disability persisted until the flat back and faulty posture had been corrected by an adequate course in physical therapy a year later. We have seen one case with persistent sciatica and loss of bladder control operated without any effect upon the symptoms. This patient had periods of relief and periods of exacerbation. All of us concerned with the case eventually were convinced that it was a functional condition—a compensation neurosis. When eventually his case was settled, all symptoms disappeared, although they had persisted for eighteen months following the operation. We have seen two cases of paresis in the lower extremities and foot drop following the operation for protruding disc. These were not present prior to the operation. Finally, there is no diagnosis and no operation feared more by the claims departments of our great insurance companies. Any of these can give you a long list of failures and of costly experiences since this operation came into vogue.

Let me reiterate that when the operation is absolutely essential it is a gift from God; when the operation is chosen in lieu of simpler methods that will give results, it becomes meddlesome surgery.

Anatomic Aspects

The normal spine is composed of thirty-two centers, twenty-four of which are movable. Not infrequently, the movable vertebrae are increased to twenty-seven. These extra vertebrae are usually in the cervical and lumbar regions and are found most often in the long-necked, narrow-chested, flat-backed, asthenic type of individual. They are significant because of the proneness of such individuals to have low back pain.

The vertebrae joined by their intervertebral discs have certain normal physiologic curves where, according to Eben J. Carey, the line of demarcation between the normal and pathologic is not fixed. These physiologic curves can be divided into primary accommodation curves and secondary compensatory curves. When one considers low back pain, the primary lumbar curve is of great importance. According to Carey, the anterior convexity of the lumbar spine is biologically an accommodation curve so arranged as to help support the abdominal viscera. Its normal secondary or compensatory curve is noted by the straightening of the lumbar spine in forward flexion movements. When this normal lumbar curve becomes acutely lordotic (the angle between the fifth lumbar and the sacrum is abnormally acute), we invariably have a potentially *weak back.* When the convexity of this lumbar curve is lost or is reversed into a concave curve, we have the typical *flat back,* or lumbar rounded back. This is the characteristic back in the majority of individuals of the Stiller or neurocirculatory asthenic type, a large percentage of whom are prone to low back pain in the third and fourth decades of life. In addition, there are ligaments joining together the articulating processes of each adjacent arch, ligaments between the spinous processes, and ligaments between the laminae. In low back pain, these ligaments must undergo contraction and stretching, thickening and thinning, and similar pathologic changes when the normal physiologic curve becomes abnormal.

There are five layers of muscles about the spinal column, adjacent and overlapping. Carey has demonstrated over 120 pairs of intrinsic muscles attached to the spine, with over 1,000,000 possible pulls. Some of these muscles are intimately attached to the spine and some more remotely removed, but, he states, "surrounding every vertebra there is a balanced muscular function."

Muscle Imbalance

It is evident, therefore, that any localized imbalance of these muscles can change the position of the vertebrae—changes which may reach the point of causing pain. Likewise, pain in some portion of the back causing a certain amount of localized spasm in the muscles usually causes the patient to assume a position of ease in order to relieve

the pain. The faulty position soon causes imbalance of muscle pull in other portions of the spine, so that a vicious circle is established which prolongs the disability. Again, complete immobilization of the spine in a plaster cast or a back brace may so limit muscle movement that contraction of muscle groups occurs—contractions which are extremely painful when subsequent movement is attempted. Frequently this immobilization is in a faulty position and causes overstretching and thinning of certain other groups of muscles, resulting in weakness. Therefore, the prolonged immobilization treatment adopted for so many back conditions, functional, disease, or injury, is often more responsible for the prolonged disability than is the original condition.

Whereas in sprains about the shoulder, knee, or ankle joint, or in fractures in or adjacent to these joints, surgeons seem to have a very clear conception of the pathologic anatomy and the importance of adapting treatment to preserve function in these joints, yet, in injuries to the spine, the joint problem is too often overlooked. In the twenty-four movable vertebrae, there are at least forty-eight joints and twenty-four rudimentary joints, any of which may sustain direct trauma to their joint surfaces, synovial sheaths, or ligaments or may sustain the traumatizing influence of prolonged immobilization similar to other joints. For example, in a compression fracture of the spine, one may see long after the fracture is healed a permanent disability due to prolonged immobilization of these joints and soft parts in a plaster cast or back brace, a disability due to stiffness and weakness from treatment rather than from the original injury.

Finally, the intramuscular fascia and the aponeurosis covering the back muscles and, in the low back, extending down over the gluteal regions and over the ilia, where it becomes attached to and is continuous with the fascia lata, are recognized today as playing a very important part in low back pain. According to Ober, many of the structural changes in the lumbar region, especially lumbar lordosis, may be attributed to contractions of the iliotibial band and of the tensor fascia lata.

In my experience, the contracted tensor fascia lata muscles are more prone to develop with flat back or with an acquired lumbar scoliosis, because both of these conditions represent faulty posture which has been acquired due to the patient's immobilizing the muscles of the back to prevent exacerbation of the low back pain. Just as the patient with a bursitis of the shoulder carries the arm adducted close to the side of his body to give relief from pain, so the patient with myositis or myofascitis in the back assumes the position of greatest ease. Both positions are faulty and, if allowed to persist, will prolong the disability for weeks and months. We recognize this condition in the shoulder but have been slow to recognize it in the back. When the tensor fascia lata becomes contracted, as it so often does, the disability is unduly prolonged. A simple incision through the contracted tensor fascia lata may be the only relief. Of more than 100 cases where this condition was present, I have incised the contracted tensor fascia lata in only 7 cases; the remainder yielded to intensive adequate physical therapy.

Care in Diagnosis

Without thoroughly studying all of the above anatomic aspects of the case, no surgeon should jump to the conclusion that a low back pain and the accompanying sciatica are due to a ruptured or herniated intervertebral disc. How long has the low back pain been present? Has it been severe enough to cause muscle spasm and the assuming of faulty posture to relieve the pain? Has this resulted in a loss of the normal curves, and, especially, has a *flat back* developed? Has a lumbar scoliosis developed, and can you be sure it was not present before? Is there a marked muscle imbalance present, and have you evaluated or considered the amount of pain this dysfunction may give? Is there a contracture of the tensor fascia lata muscles which can account for much of the pain down the thighs? Are there arthritic changes present which suggest those numerous changes in and about the neurocanal which Schmorl ascribes to functional trauma or to the wear and tear of an active life? Has there been any change in habits

such as, for example, from an active to a sedentary life? Is the patient obese, and has the load become gradually too heavy for the spine? Has the protuberant abdomen pulled the spine into a gradual acute lordosis or *weak back?*

These and many similar conditions will give the identical symptoms which are now ascribed by some to derangement of the intervertebral disc or nucleus pulposus.

Try Simpler Treatments First

The answer to these questions can not be learned at one examintion. Bed rest on a hard, flat mattress (a fracture board under the mattress) with continuous heat to the spine and even sedatives to relieve the pain must be used until the condition has subsided. As soon as possible, restoration of the normal lumbar curve must start. Heat and massage followed by corrective exercises gradually increasing in intensity are then used. If a flat back is present, sleeping first on a soft pillow placed under the small of the back, then on a hard blanket, and finally on a hyperextension apparatus will overcome this condition. The patient must be taught to move and use his back in normal functional directions, and all faulty habits to relieve discomfort must be corrected. Diversional and, later, purposeful occupations should be prescribed. Special attention must be directed by the physical therapist to those muscles which remain contracted and especially to the tense aponeurosis and tensor fascia lata. She must do this without calling undue attention to these parts. The surgeon must see the patient every day, supervise the treatment, and observe the results thereof. If this treatment fails to give results, and if neurologic symptoms persist or increase, then and only then is one justified in positively diagnosing a ruptured intervertebral disc and in operating for it. A similar plan should be followed in the majority of these low back conditions ascribed to spondylolisthesis before fusion of the spine is advocated. No operation for the contracted tensor fascia lata muscle is indicated until these simpler methods have been exhausted. Even after operation, they must be used.

Analysis of Cases Treated

In the last three years, we have examined approximately 300 back cases. During this period we have treated approximately 200 cases with low back pain, the majority of which were alleged to be traumatic, and many of which had received inadequate physical therapy, manipulative treatment, "shot" treatment, recommendations for operations, or actual operations. In only two of these was the diagnosis of a ruptured disc made, and these patients were referred to the neurosurgical department. One of these cases refused operation, left the hospital, accepted settlement from the insurance company, and, when last heard from, was working on his brother's farm in Wisconsin. In another case, operated by Dr. Oldberg and myself, no herniated disc was found. The back was then fused. The patient failed to recover. Later, in another city, he had a cystotomy. This closed within six weeks. He continued to complain of back pain. He then developed spells which, on further study in our hospital, were proved to be malingering. This man recovered after a settlement was made. Practically every one of the remaining cases recovered and returned to work. In the great majority, no settlement for any permanent disability was necessary or was made. A few of the cases required months of treatment, but the majority responded within four to six weeks.

At least 150 of these cases were referred for treatment after they had been treated elsewhere as injury cases. In every instance, a minor trauma, such as lifting, or a sudden strain thrown on the back by a fellow employee's dropping the other end of a heavy object which they were carrying, or being jerked by a train, had been assumed to be responsible for the condition. In a high percentage of the cases, the condition was a typical myositis or lumbago with the sequelae of faulty posture, contracted muscles, and muscle imbalance due to assuming the position of ease. The great majority of the cases were the Stiller type or the psychogenic individual. Two of the patients had metastatic carcinoma, and two had Pott's disease, all undiagnosed. In one the back pain was due to gall stones, in another to a

penetrating ulcer, and in a third to a chronic retrocecal appendicitis. Treatment of these conditions at least gave relief to the back pain. Several of the patients were markedly obese, were referred elsewhere for treatment of their obesity, and, when the obesity was relieved, their back pains disappeared.

Of these 150 patients, 36 had had the operation for nucleus pulposus or herniated disc recommended to them. One had been operated for this condition.

Case Reports

Case I. Mr. H. H., age 36, an expert machinist, had lifted a heavy casting a year prior to admission to my service. He suffered an immediate severe pain in the back and was sent to the company doctor. He was given short-wave treatments and, after a week, was able to return to work. Two weeks later the severe pain struck him in the back again when he lifted a light object. The pain persisted in spite of heat treatments and soon radiated down the leg. He complained of some numbness on the outer aspect of the leg. After three months, he was referred to another surgeon, who made a diagnosis of ruptured intervertebral disc. A neurosurgeon was called in consultation and confirmed the diagnosis. The original surgeon, a man with wide experience in surgery of trauma, then operated this case. His operative record showed that he explored between the fourth and fifth interspace without finding a ruptured disc, but he did find the ligamentum flavum markedly thickened. This was not incised and the intervertebral space explored as recently recommended by Dandy. Following this operation, the patient continued to complain of his backache and radiating pains down his leg. After three months he was again examined by the neurosurgeon, who recommended another exploration on the basis that the protruding disc was present but was not found. A second neurosurgeon was called in consultation. He recommended nonoperative, conservative treatment. No iodized oil was injected in this case, as it was a compensation case. This was fortunate.

This patient was referred to me in April, 1942. Examination revealed a tall, narrow-chested, long-waisted individual with a very narrow intercostal angle and a protuberant lower abdomen. He gave a history of indefinite gastrointestinal symptoms for years. Typical of the majority of such individuals, he had a markedly flat back, in fact, a reverse curve in the lumbar region. The back muscles were tight and became spastic on any movements that tended to restore the normal lumbar curve. The Ober's test for contracted tensor fasciae latae muscles, was present. The patellar and Achilles reflexes were normal, and there were no changes in sensation.

This patient was placed on a regime of physical therapy which included heat, massage, and corrective postural exercises. He was taught to walk on his tiptoes in a pigeon-toed position. At the same time, he was instructed in sucking in his belly and in breathing with his diaphragm. Being told to grasp each lower costal margin and to spread them as he breathed deeply, he was quite proud of increasing the width of his intercostal angle. Within a couple of weeks he was working in the occupational therapy department. Within two months all signs and symptoms of the low back pain and sciatica had disappeared, and the patient was discharged.

Unfortunately, he had secured a lawyer before coming under my care. He was so pleased at being restored to health that he tried to get rid of his lawyer. The latter insisted upon a settlement, which was made by the insurance company. The patient, last seen in July when he was going to his home in southern Illinois, stated that he was going to enter the army.

Case II. Mr. W. J., age 58, an executive in a public utility concern, had led a very active outdoor life. He played golf and was a hunter. He had never had any trouble with his back. Early this year he was called to Washington, where he took charge of one of the numerous bureaus. He worked from eight to twelve hours a day sitting slumped at a desk and dictating most of the time. As he expressed it, he became a "tail sitter." When the weather became quite warm, he secured an electric fan and slept one night with this blowing on him. The next morning he had a sore back. This backache increased until, at the end of a week, he was bent over and could hardly get to his office. He consulted an osteopath. The first two treatments helped, but the third treatment made him worse. At the end of three weeks, he developed pain down the back of his leg and a sense of numbness and burning in the outer aspect of his ankle. He then took a leave of absence and tried a period of bed rest. After six weeks he consulted an orthopedic surgeon, who recommended a roentgenogram. In the roentgen-ray report, the roentgenologist stated that he could find no evidence of disease of or injury to the spine. However, he called attention to a peculiar shadow in the neck of the left femur which should be further investigated by roentgenography. Evidently no attention was paid to this suggestion. The patient was referred to a neurologist who examined his nervous system and then referred him to a neurosurgeon. The latter asked if sneezing increased the pain. When assured that it did, he diagnosed a herniated disc and then recommended operation. According to the patient, the entire time spent at the hospital was thirty minutes. When asked about the diagnosis and recommendation, the orthopedic surgeon agreed that if the neurosurgeon thought it was necessary, he better let him do it.

Through a mutual friend, the patient was referred to the author. The complete physical examination was negative, except for a slightly enlarged prostate with a small nodule in the left lobe. The

examination of the back showed a marked flat back and a protective scoliosis to the right brought on by an attempt to relieve the pain in his left leg. Forward flexion could be performed only to about twenty degrees. The patellar and Achilles reflexes were present, although the left Achilles was slightly reduced. There were no changes in sensation. There were no bladder or rectal symptoms.

The patient was referred back to the roentgenologist for further study of the left femur neck, which had shown a vague shadow in the original films. Because of the enlarged prostate and especially a slight nodule, a metastatic condition was feared. This roentgenogram, however, revealed a rather large area of decreased density resembling somewhat an old osteitis fibrosa. It was not malignant. The genitourinary specialist examined the prostate and pronounced it nonmalignant. The slight enlargement felt was an enlarged seminal vesicle.

This patient was likewise placed on intensive physical therapy with continuous heat to the back for a few days, followed by heat, massage, and corrective exercises. He was extremely nervous and had developed a spastic bowel. The latter was relieved by small doses of tincture of belladonna and elixir of sodium phenobarbital. The very significant point in this patient's history was the fact that for years he had taken six to eight highballs a day. He thought it was possible that he drank more than this after going to Washington, although he never got drunk. His whiskey was eliminated, and he was placed upon vitamin B on the possibility that some of the sciatica might be due to an alcoholic neuritis. After he had been under treatment for three weeks, all signs and symptoms disappeared. He has been back at work in Washington for some time, and a recent letter from him states that he has had no recurrence of his trouble.

Like so many of the rest of us who have recurring attacks of lumbago, sometimes with sciatica, this man may have an intervertebral disc herniated into his neurocanal. So may the rest of us. How do we know that these small protruding discs are not almost as common as arthritic spurs on the spine? Occasionally these arthritic spines become exceedingly disabling. Occasionally these herniated discs may become intractable. But, like the majority of arthritic spines, they may only occasionally give the recurring lumbago and sciatica. I have ten doctor friends who, like myself, have these recurring attacks of low back pain and sciatica. In only one of these do we feel that an exploration of his spine is indicated. He frowns upon this suggestion. The remainder of us prefer to carry on without the operation.

Conclusions

1. Low back pain, even with sciatica, is not always due to pathologic conditions inherent in the spine itself. There are many anatomic and constitutional factors which may be responsible for the condition.

2. Every case should be thoroughly studied before one jumps to the conclusion that the low back pain is due to an alleged trivial injury, usually overlifting, a maneuver which the patient has performed dozens of times a day for years.

3. The vicious circle of myositis or myofacitis, muscle imbalance, and faulty posture assumed to relieve pain, with the increased muscle imbalance that follows, must be considered and corrected in every case before one concludes that the back needs a fusion or a herniated disc operation.

4. The Stiller or asthenic type of individual and other psychogenic types make up a high percentage of the cases with low back pain often accompanied by sciatica. More often, these have recurrent instead of constant backache. Operations of any kind often will help these individuals temporarily, but sooner or later their trouble recurs, or some other hypochondriac lesion develops. These are the patients who respond best to corrective exercises, occupational therapy, and encouragement to correct their mental attitude.

5. There are many organic constitutional diseases which can cause low back pain. These must all be ruled out before localizing and attacking the condition in the low back. It is embarrassing to operate a spine and later find it to be the seat of a metastatic carcinoma. Disease in the genitourinary tract, the pelvic organs, the gastrointestinal tract, and the gall bladder not infrequently manifest themselves by low back pain.

6. Unquestionably, there are spines which must be fused. Unquestionably, there are herniated discs which must be removed. However, before one concludes that the given patient belongs in either category, days and weeks of observation and conservative treatment should be instituted. When

treatment fails to relieve, when repeated examinations fail to reveal other causes, when the psychogenic element has been eliminated, and when the signs and symptoms definitely locate the offending pathology in the lower spine, then and only then should operation be performed. The same rules should apply before placing the patient in a plaster body cast for weeks or months or dooming him to wear a cumbersome back brace.

BIBLIOGRAPHY

1. Dandy, Walter E.: Serious Complications of Ruptured Intervertebral Disks, J. A. M. A. 119:474 (June 6) 1942.
2. Dandy, Walter E.: Concealed Ruptured Intervertebral Disks, J. A. M. A. 117:821 (Sept. 6) 1941.
3. Duncan, William, and Hoen, Thomas I.: A New Approach to the Diagnosis of Herniation of the Intervertebral Disc, S. G. & O. 75:257 (August) 1942.
4. Beadle, Ormond A.: The Intervertebral Disks, Great Britain Medical Research Council, Special Report Series, no. 161, London, His Majesty's Stationery Office, 1931.

Abdominal Apoplexy

Report of Two Cases

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ABDOMINAL apoplexy may be defined as an acute hemorrhage occurring in an abdominal organ and precipitated by a condition of arteriosclerosis. Hypertension is often an associated finding, the symptoms depending somewhat upon the size and location of the arterial defect. The pathologic sequence of events may be described as a loosening of the calcified sclerotic plaque on the intimal wall of the artery, followed by a forceful dissection of the blood through the muscularis and adventitia and continuing unrestrained outside the blood vessel. Hemorrhage from new growth, trauma, intra-abdominal disease, or aneurysm must not be confused with abdominal apoplexy.

By 1940, 13 cases had been reported in literature, all diagnosed after surgery or autopsy. The predominant symptoms were abdominal pain and shock in patients who were hypertensive, sclerotic, or both. In one of the cases, the physician reported that the symptoms and signs were very similar to those of a ruptured ectopic pregnancy.

Case Reports

Case 1. Mr. G. K., age 69, a farmer, married, was admitted to the hospital on March 4, 1938. He had been under medical supervision for several months because of hypertension and hypertensive heart disease. On March 2, he suffered acute upper abdominal pain which was sharp and crampy in character and associated with nausea. The next morning he had a small liquid stool. The abdomen became tender and distended, the pain now being chiefly in the left lower quadrant near the flank. An enema was attempted, but only about a pint of fluid was admitted. This caused distress and was expelled. Since there had been some change in bowel habit, large bowel obstruction was considered, and he was referred to the hospital. A barium enema was administered, although the roentgen-ray department advised against this because of his condition. The barium went only to the hepatic flexure, and a defect in the sigmoid colon was suggestive of a pathologic condition. The roentgenography was not satisfactory, however, as the injection caused considerable distress, and the patient went into shock while on the roentgenography table.

A cecostomy, which was considered the best procedure, was done under local procaine anesthesia. When the peritoneum was opened, gross blood was found. The operation was completed and the distention relieved. Because of the patient's poor condition, further exploration was deemed inadvisable. It was feared that injection of the barium had done some damage and that hemorrhage had resulted.

The patient responded favorably, and supportive treatment was administered. He became unresponsive and restless on the fourth postoperative day, developed pulmonary complications, and died on March 10.

Autopsy Findings

The autopsy report is as follows: "Diffuse, confluent, lobular pneumonia; marked cardiac hypertrophy and atherosclerosis of the thoracic vessels; dark, thick, red blood still in the fluid state in the abdominal cavity, chiefly in the pelvis and lateral portions, more so on the left; marked atheromatosis with complete thrombsis of the entire left gastric artery with distinct softening of its wall but without evidence of aneurysmatic dilatation; distinct

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distention and atrophy of the wall of this artery, especially in its upper course. A superficial defect only 2 mm. wide in the anterior surface of this thrombosed artery about 2 cm. above the main stem of the hepatic artery was evident. No significant disease was noted in the intestines or other abdominal organs."

Whether the thrombus developed before or after hemorrhage was not stated.

Case 2. Mrs. F. G., age 83, widowed, was admitted to the hospital on January 27, 1941, complaining of severe abdominal pain and weakness following an aura of sudden faintness and numbness in the arms, progressing over the chest and abdomen leading to syncope. At 2 p. m., she collapsed while washing dishes and was unconscious for about an hour. When she regained consciousness, she was having severe, steady abdominal pain and had vomited. At the time of hospitalization, 5:20 p. m., she was pale and very ill and was breathing with difficulty. The patient said she had been perfectly well and had not consulted a doctor for forty years, and her family reported that she had appeared well and had had good color until her present illness. However, questioning revealed that she had had occasional headaches for the last year, with ringing in the ears and transient spells of diplopia. There had also been a brief spell of faintness and shortness of breath after exertion in the summer of 1940.

Physical examination revealed a well developed, well nourished, white female, apparently 80 years of age, who appeared extremely ill and had marked pallor. She was in extreme agitation from pain, in a cold sweat, and presented the picture of "air hunger."

Her temperature was 99.6 F., pulse rate 96, and respiration 42. Ophthalmic examination showed markedly pale conjunctivae and markedly sclerosed retinal vessels. The buccal mucosa was very pale. The heart was fast and had a poor tone. The blood pressure was 80 systolic and 60 diastolic, and the pulse was palpable but weak. Slight radial sclerosis was noted.

Abdominal examination revealed distention. She held the muscles very tight, and pressure caused acute pain. The muscles were spastic with the chief resistance on the right side, although there was slight relaxation on expiration. A suggestive mass was felt on the right side opposite the umbilicus. Peristalsis was slight.

Laboratory Findings

Laboratory examinations revealed the following: January 28, 1941—hemoglobin 10.4 Gm., red blood cell count 3,250,000, and white blood cell count 10,-250; January 29—urinalysis showed a trace of albumin and 10 hyalin casts per low power field; February 3—hemoglobin 8.5 Gm., red blood cell count 2,880,000, and white blood cell count 9,400. The Wassermann reaction was negative.

The preoperative diagnosis was abdominal apoplexy with a question of mesenteric thrombosis. On January 28, an exploratory operation was performed through an upper right rectus incision with the following findings: "On opening the abdominal cavity, there was an increased amount of serous fluid. At the mesenteric attachment of the ascending and transverse colons, the cecum, and the terminal ilium, there was found a hemorrhagic area that was infiltrating this structure and, as a hematoma, was causing great swelling and a dense thickening about the vessels that supplied these structures. This extended to the midportion of the transverse colon and to about the midline on the left. The hematoma separated the layers of the mesentery, pushed the cecum forward, and extended to the lateral side of the cecum and ascending colon, where it appeared as a large hemorrhagic bleb. Hemorrhage was considered as arrested. There was no evidence of the serous surface of the mesentery being ruptured. The circulation of the abdominal viscera and of the said involved parts did not seem to be impaired, as the gut itself had a pinkish gray color and no evidence of cyanosis. The rest of the abdominal viscera presented no abnormality."

Roentgenographic Findings

Three postoperative roentgenograms revealed the following findings: "February 4, 1941—bedside flat plate (without Bucky) showed suspicious small shadows in and about suspected area. Possible sclerotic plaques. Also noted on the left side near the spine.

"February 22—Stereoscopic roentgenogram of the abdomen demonstrated an oval-shaped mass about 6.5 by 5 inches. Its lateral and superior borders were outlined by the ascending and transverse colon, the ascending colon being pushed forward by it. The left lateral and inferior borders were demarcated by a line which extended from the cecum across the lower border of the right transverse process of the fifth lumbar vertebra; this extended across the spine in an upward direction between the fourth and fifth transverse processes and directly upward to meet the transverse colon. The colon was well outlined by its gas content. The hepatic flexure was rounded out by the mass. The mass extended one inch to the left of the third lumbar vertebral body. The calcified densities on the left seemed to lie behind the mass and might be described as being in the abdominal aorta. A calcified density about 0.5 inch long was noted over the mid-portion of the right second lumbar process which lay well above it and within the mass.

"March 10—A flat plate showed a dissolution of the mass with the calcified densities remaining."

The patient made satisfactory progress following operation. The pain, tenderness, and distention disappeared after a few days. Evidence of secondary anemia persisted. The highest blood pressure recorded was 190 systolic and 85 diastolic, and the average was about 160 systolic and 85 diastolic at bed rest.

Because of the obvious signs of acute intra-abdominal hemorrhage in an aged patient who was obviously arteriosclerotic, a diagnosis of abdominal apoplexy was made. It is of special interest that the pain did not occur until after recovery from the syncope. If the peritoneum had ruptured at once, the pain would probably have been immediate, as the parietal peritoneum would have been irritated. Being confined between the layers of the visceral peritoneum (mesocolon), the hemorrhage did not produce irritation until it reached such a size that it stretched the peritoneum and produced pain. This is a diagnostic point to be remembered.

Conclusions

1. Two cases of abdominal apoplexy are presented. In one case, the diagnosis was made at autopsy; in the other, the diagnosis was made clinically and confirmed by surgery.

2. Abdominal apoplexy is a definite clinical entity and should be included in the differential diagnosis of abdominal catastrophies in the aged, sclerotic, and hypertensive patient. If a diagnosis of mesenteric thrombosis is made, look further for any evidence of hemorrhage.

3. Acute abdominal pain in the aged, with acute pallor following an aura of faintness, numbness, and syncope, might be considered as pathognomonic of abdominal apoplexy in which the hemorrhage is still confined between the layers of the visceral peritoneum. If the peritoneum ruptures, then the signs and symptoms simulate those of an ectopic pregnancy rupture.

4. It is not improbable that this condition has been missed in the past, either because it was so minor that the patient did not come to surgery, or because sudden death resulted, the cause of which was attributed to cardiac disease without performance of an autopsy.

Surgical Scarlet Fever

By MAX J. FOX, M. D.,* and MAURICE HARDGROVE, M. D.**

Milwaukee

THE classic case of scarlet fever is easily recognized. It manifests itself as a triad consisting of a sore throat, a punctate rash, and a glossitis. It is commonly followed by desquamation of the tongue, hands and feet.

Frequently we find a syndrome resembling the classic case except for the location of the original site of bacterial invasion. To stress the injury or operation which precedes this type of case and for the want of a better name this has been called "surgical scarlet fever." The foci in these cases are elsewhere than in the throat.

The following cases are examples of this type of scarlet fever:

Postoperative Case

Case No. 92 S. S.

This case was that of a 35 year old female who had a pelvic operation and an appendectomy performed seven days before a pin-point rash appeared over her entire body. There was no history of exposure to scarlet fever, nor did she have a sore throat, although the tongue resembled that of an early case of scarlet fever. The temperature was 102 F. when the rash was noted. The suprapubic wound was healed except for three small openings from which serosanguineous fluid was draining. The white blood count was 32,450. The differential count showed 85 per cent polymorphonuclears. The following day the temperature rose to 104 F. and at this time she was given 40 cc. of human convalescent scarlet fever serum intravenously, and 10 cc. of the same substance were injected into the wound openings. The temperature fell to normal within twelve hours, the rash faded, and the clinical condition improved. A week later, because of persistent wound drainage, 20 cc. more of convalescent scarlet fever serum were given into the openings.

The wound culture showed hemolytic Streptococci originally but was negative on discharge. The patient recovered completely.

Post-traumatic Case

Case No. 12 C. S.

A child, age 5, had an automobile accident eleven days before the rash appeared. At the time of the accident he suffered multiple contusions and abrasions. No history of exposure to scarlet fever could be obtained. On admission, the tongue reddened with elevated papillae, and there was a beefy red pharynx. A few days later the left eye showed edema of the lid, and there was a forward protrusion of the eyeball. Sixty cc. of human convalescent

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serum were given intravenously. In two days the swelling had improved so that it was hardly perceptible. Further convalescence was uneventful, and the patient was discharged on the twenty-first day after hospital admission.

Postpartum Case

Case: Mrs. B.

This young married woman, age 20, was delivered of her first child by forceps three days before a scarlatiniform rash was noted on her body, most intense about the pelvic region. No history of exposure to scarlet fever could be elicited. The patient was delirious. Although her tongue had the characteristics of an early case of scarlet fever, there was no sore throat. There was a moderate serosanguineous vaginal discharge present. Her temperature was 104 F. Eight hours after 100 cc. of convalescent scarlet fever serum were given, her clinical condition was greatly improved, the temperature was normal, no delirium was present, and the rash was lessening. After four days an abscess was found in the left broad ligament which consequently subsided.

Post-traumatic Cases

A most interesting group of cases is the following:

A child, age 3½ years, developed scarlet fever, which was later complicated by a mastoiditis. This was operated on, and the child with an open draining wound, was discharged to his home.

The mother developed, through an abrasion on her hand, lymphangitis of the arm, which was followed in two days by a typical scarlet fever rash. She received 60 cc. of convalescent scarlet fever serum intravenously, as well as hot compresses to her arm and hand. Within twenty-four hours the rash disappeared and her temperature returned to normal. Otherwise the convalescence was uneventful.

The father, during the mother's absence, continued to dress his son's draining mastoid. He likewise had an abrasion on the proximal phalanx of the index finger of the right hand. He developed lymphangitis, a septic fever curve, but no rash appeared.

The organism in all these cases was found culturally to be the same. A toxin was prepared from the organism which was as effective as any commercial toxin. This toxin was neutralized by commercial scarlet fever antitoxin and convalescent serum.

The hemolytic Streptococcus is capable of producing the syndrome known as "surgical scarlet fever," even when gaining entrance into the body from sources other than the throat. As in cases of scarlet fever of the more classic variety, the patient's native antitoxin is low when he develops the typical rash. When the rash does develop, it fades when neutralized by the horse serum antitoxin or human convalescent scarlet fever serum. These cases respond satisfactorily to convalescent scarlet fever serum as do other cases of scarlet fever. As in classic scarlet fever, toxic and bacterial complications occur, tending to be most marked close to the point of entrance of the organism into the body. Blood stream infection (septicemia), so rare in regular scarlet fever, is not uncommon in these cases. Sulfanilamide and its derivatives have a definite place in the complications of the disease, but are of no value to neutralize the original toxemia. Supplementary surgical procedures are necessary for the removal of purulent accumulations.

Conclusions

"Surgical scarlet fever," as defined, is a syndrome resembling classic scarlet fever. It differs mainly in that the focus of bacterial invasion and toxin production is elsewhere than in the throat. It frequently follows traumatic or surgical implantation of the Streptococcus haemolyticus into a wound.

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Disorders of the Newborn

By SAMUEL E. KOHN, M. D.
Milwaukee

IT IS a well known fact that the greatest number of babies are delivered by the general practitioner. Any attempt, therefore, to reduce the mortality and the morbidity of the newborn cannot succeed without his complete cooperation. This success depends upon his ability to recognize abnormal conditions in the newborn and properly evaluate his findings, to the end that prompt treatment may be started before the condition becomes too grave.

At no time in life is speed so imperative as in the newborn. Unrecognized or improperly recognized conditions may result in early death if not promptly relieved. Examination of the newborn should not be delegated to some incompetent associate, be it doctor or nurse. I am well aware of the fact that every practitioner cannot be thoroughly trained in pediatrics. I believe, however, that if he can recognize the abnormal and can ask for assistance from some qualified consultant, he will conscientiously discharge his obligation to his patient as well as to himself. In this short paper, it is obviously impossible to mention all the disorders of the newborn, and I will, therefore, confine myself to the most common.

Cyanosis

Cyanosis is a common finding and frequently becomes a serious diagnostic problem in spite of all that is known about it. Before a final diagnosis is reached, the following principles should be carried out:

1. Keep air passages as clear as possible.
2. Supply sufficient warmth.
3. Give free supply of oxygen.
4. Apply gentle respiratory stimulation.

Cyanosis may be considered from two standpoints:[1]

1. **Primary**—in which there are obstructions to the air passages due to mucus and inspired sac contents, weakness of the respiratory mechanism as found in prematurity and congenital abnormalities, and lung disturbances such as atelectasis, pneumonia, or congenital absence of one or more lobes.
2. **Secondary**—due to mixture of the venous and arterial blood as in congenital heart disease, failure of the respiratory center as in increased intracranial tension due to injury or hemorrhage, and pathologic development of the brain and center.

Obstruction due to mucus or aspirated amniotic sac contents may be relieved by use of a rubber bulb with a soft tip or a number 12 French catheter which, with a little practice, can be introduced into the trachea. Gentleness is the watchword, and lack of it often produces injury to the mouth, pharynx, and trachea. Aspiration of amniotic sac fluid by infants has been demonstrated in 88 per cent of those dying in the first days of life, according to Farber and Sweet.[2] This emphasizes the importance of prompt and thorough attention after birth. No attempt should ever be made to force the infant to breathe until the passages are well cleared. This obviates the aspiration of foreign material into the lower respiratory tract.

Cyanosis associated with weakness of the respiratory muscles and pathology within the lung itself is often difficult to diagnose except by roentgenogram. Every attempt should be made after the passages are cleared to stimulate respiration and supply the much needed oxygen. Deep breathing should be emphasized in an attempt to expand and completely aerate as much of the lung as possible. Gentle rubbing and patting or the discreet use of cold water or ether will often initiate and stimulate deep respiration. Carbon dioxide combined with oxygen (5 to 95) stimulates the respiratory center. Too much carbon dioxide or stronger concentrations can be dangerous, since they may ag-

gravate an already existing acidosis. This is particularly true in severe asphyxia.[3, 4] In an effort to expand the lungs and, therefore, to force air into the chest, other means of stimulating respiration, such as flexion of the trunk followed by extension, can be used, but not without some element of danger, especially if intracranial hemorrhage is suspected. It should not be used, however, unless the infant has already breathed.

Atelectasis

Atelectasis is a frequent finding. It is often characterized by cyanotic attacks of varying degrees rather than by persistent cyanosis. A roentgenogram of the chest will demonstrate this lesion. When the condition is extensive, the percussion note is dull over the affected part, breath sounds are diminished, and moist râles may be heard. More frequently, physical findings are entirely negative. One should always be suspicious when there are fleeting cyanotic spells in newborns who do not cry well or breathe deeply. Every attempt should be made to force these infants to breathe deeply through either the medium of crying or the continued use of carbon dioxide and oxygen. Insufflation is a procedure of last resort and should be used only when the child fails to breathe by other means. It should never be tried unless the passages are clear. Vigorous attempts to inflate the lungs in this way may cause rupture of the alveoli, pneumothorax, subcutaneous emphysema, and allied conditions which usually result in death. Mouth to mouth breathing probably depends for its effect upon the carbon dioxide given off by the donor as much as upon the pressure of the air forced into the lungs.

Pneumonia

Pneumonia in the newborn is a more common cause of neonatal cyanosis and death than was formerly supposed.[5] Autopsy records show that from 10 to 15 per cent of deaths in the first few days of life are due to pneumonia. Infection is due to aspiration from the upper air passages into the lung. Fever and physical findings are very seldom present except in prolonged cases and, undoubtedly, many recover without being recognized. Increased respiratory rate without any other causes should make one suspicious, and a roentgenogram of the chest substantiates the diagnosis.

Congenital Heart Disease

Congenital heart disease, with its frequent accompanying cyanosis, should be recognized if only to know when to leave the child alone. However, one should not be hasty in giving a bad prognosis in these cases. In many instances there is a decided improvement as the child grows older and the heart compensates for its deformity. Diagnostically, these murmurs are heard constantly, and the cyanosis is persistent and usually is aggravated by crying.

Intracranial Pressure

Cyanosis associated with intracranial pressure may be due to trauma, hyperemia and edema, frank hemorrhage, or skull fracture. The pressure usually causes an anemia of the medulla and an interference with the respiratory center. Difficulty in swallowing, irritability, and fleeting cyanosis often point to the diagnosis.

Vomiting

Vomiting is the most common symptom in children. Air swallowed with the feeding invariably rises and forces up a small amount of food with it. Because vomiting is so commonly found, the more serious aspects of this symptom may be overlooked. The frequent practice of attributing all vomiting to the food and changing with frenzy from one food to another because of it often results in a wasted child who has a difficult convalescence when other measures are instituted. It is obvious, therefore, that one must differentiate between the simple and serious causes of vomiting. So-called serious vomiting, if not associated with intracranial irritability, is probably due to obstruction somewhere in the intestinal tract. This may occur at the cardiac end of the stomach as a result of spasm or frank organic stenosis, or, more commonly, at the pyloric end. Pyloric obstruction may be due either to spasm or actual hypertrophy.

As its name indicates, pylorospasm is only a spasm, and obstruction occurs only during the active phase. It comes on shortly after birth and is not a progressive condition. While there is very little weight increase, these children do not suffer greatly and frequently have good stools in spite of food loss. In true hypertrophic stenosis, however, the increased size of the tumor mass causes a gradual but progressive occlusion of the pyloric orifice. Vomiting is constant and projectile and increases in amount and intensity. There is gradual, continuous loss of weight and increased dehydration. The stools, because of lack of food entering the bowel, decrease in amount and frequency and become small, greenish, shiny, and curd-free. Examination of the naked infant will often reveal the diagnosis: obvious loss of weight, poor tissue turgor, dehydration, and visible peristalsis appearing immediately after feeding and moving across the abdomen from left to right and then back again from right to left associated with projectile vomiting.

It is important to recognize and differentiate these conditions early, as treatment and progress depend upon their recognition. In the former, diet consisting of thick cereal together with some antispasmodic, especially some member of the belladonna family, will frequently overcome the spasm. In the latter, because of organic obstruction, surgery is *not only indicated but imperative.* To allow a hypertrophic stenosis to go on to serious dehydration with its accompanying toxicity makes the ultimate outcome after surgery extremely doubtful. The operation of choice is the Fredet–Rammstedt pyloromyotomy, which, in the hands of a skilled surgeon, is very simple. Fluids should always be given to the dehydrated child preoperatively. It is surprising how quickly these children respond to proper feeding after a successful operation.

Hemorrhage

Hemorrhage is relatively common during the first few days of life. The tendency for prolonged bleeding and clotting time during that period is a well established fact.[8] There is a failure of the foetus to store sufficient prothrombin to be used after the first twenty-four hours of life. Low prothrombin alone does not necessarily produce hemorrhage. Trauma and sepsis play an important role. Melena or bleeding into the gastrointestinal tract with its accompanying tarry stools is not uncommon and, up to the present time, has been treated by the use of blood given intramuscularly or intravenously. More recently, the use of vitamin K given hypodermically or by mouth has been the treatment of choice. Vitamin K requires approximately one-half to two hours to manifest its initial effect. If more rapid coagulation is necessary, a transfusion should be given immediately.[8] Intramuscular administration of vitamin K derivatives has been found to be less effective than the oral or intravenous routes.[9]

It should be emphasized that trauma alone is not the only cause of intracranial hemorrhage. It has been found after normal or precipitous deliveries and even after cesarean sections. The recent use of vitamin K in the mothers just before delivery will, undoubtedly, tend to lessen the incidence of intracranial hemorrhage in the newborn.[7, 10–14] Daily administration of oral vitamin K to the mothers for from two to sixteen days before delivery had no effect on the mother's prothrombin time but produced a shorter time in the cord blood.[7, 12] No ill effects were observed in either the mother or the baby from this prolonged use. This form of treatment supplemented with the giving of the vitamin K to the newborn infant should prove very beneficial.[13] Feeding the mother a diet high in vitamin K ante partum failed to show any effect on the prothrombin level of the newborn and, therefore, cannot be depended upon alone to assure an adequate prothrombin level.

Intracranial hemorrhage produces symptoms of intracranial pressure. Hyperirritability, as well as somnolence, may be found. The high-pitched, so-called cephalic cry is a frequent finding. Failure to nurse and difficulty in swallowing should make one suspicious. In more severe cases, twitching, nystagmus, cyanosis, and frank convulsions are elicited. Although it is frequently present, bulging of the fontanel may not be found in many cases, particularly in subtentorial

lesions. An attempt should be made to differentiate between simple edema or hyperemia and frank hemorrhage. The Moro sign or embrace reflex is of value in attempting to differentiate between the two. It is elicited by striking the table on which the baby lies, by suddenly lowering him a short distance, by startling him with a loud noise or by a slight, quick blow to the body. Normally the arms are thrown out impulsively, following which they are brought together in a jerking manner. The hands are fanned and then tightly clenched. Absence of this reflex on one or both sides indicates intracranial pathology. In simple edema or hyperemia the reflex is absent at birth but appears after the second or third day. In frank hemorrhage the reflex does not appear until the sixth or seventh day. The best treatment for intracranial hemorrhage is its prophylaxis, which should result in a decreased incidence when properly carried out. It has recently been shown that the promiscuous use of many sedatives and hypnotics before or during labor has a marked influence on the incidence of cerebral difficulties in the newborn.[11] Cole has shown that these drugs cause changes in the osmotic tension and may influence bleeding. The routine use of vitamin K in the newborn with or without suspicion of injury is recommended. No drug, however good, can compensate for violent, unnecessary trauma during or after delivery, with its possible injury and hemorrhage.

Caput Succedaneum

The well known condition called caput succedaneum consists of a boggy swelling which is usually situated over the parietal or occipital region of the head but which may occur in any portion of the body as a result of pressure at the cervix. There is an infiltration of lymph into the soft tissues. It can be of any shape or size and, when on the head, must be differentiated from a cephalematoma. A caput usually disappears spontaneously without any residue. No treatment is necessary.

A cephalematoma is an extravasation of blood beneath the periosteum. It is usually external but may, in unusual cases, be found internally, in which instance the blood collects between the dura mater and the bone. It is produced by the contraction and relaxation of the uterine musculature and occurs over that portion of skull which is presented. It often is associated with difficult labors. It is found most frequently over a parietal bone, over the right more often than the left. For the first few days the swelling is rather tense, after which it is somewhat fluctuant over the top. An irregular margin, probably due to a deposit of the lime salts over the periosteum, can be felt around the base. Cephalematomas frequently disappear spontaneously within the first three to four weeks. If it persists, aspiration may be necessary, as a bone cyst occasionally may form if absorption does not take place. The aspirated matter is a chocolate brown liquid. Great care should be taken not to infect the scalp during aspiration.

Infection

The skin of the newborn is very delicate and takes on infection easily. As a result of its prolonged water bath in the uterus, the skin fails to have normal resistance for at least two weeks.

The most common skin lesion is impetigo or pemphigus of the newborn. This condition is the scourge of the nursery and something about which anyone connected with the newborn should be greatly concerned. Anyone who has seen such an epidemic realizes the extreme difficulty with which it is controlled. Many attempts have been made to prevent its development, and to this end many treatments for the newborn have been devised. Ranging from the application of lotions to the use of ointments containing everything from ammoniated mercury to sulfathiazole, many methods have been used. No one method has been successful. It appears that epidemics of impetigo occur spontaneously in various parts of the country at the same time. Approximately three years ago, during the epidemic in Milwaukee, similar epidemics were experienced in other hospitals throughout the country. In an attempt to reduce trauma to the skin of the newborn, bathing has been eliminated, and only the

head and face have been wiped clean. The vernix caseosa has been allowed to remain on the skin. Some hospitals claim excellent results with this method. Impetigo of the newborn occurs most frequently at points of friction where warmth and moisture occur, namely the neck, axillary spaces, inguinal folds, and across the buttocks and lower abdomen. Excessive heat and clothing seem to predispose. The lesions range in size from a split pea to a 25 cent piece and may become confluent. They are first vesicular and then pustular and are followed by crusts which are yellow and honey-combed. They usually contain Staphylococcus, but Streptococcus occasionally may be seen. Treatment is best carried out by leaving the child unclothed as much as possible and by using some nonirritating antiseptic which dries rapidly. New blebs may be opened readily and some cauterizing substance applied.

No paper on disorders of the newborn would be complete without reminding the physician to examine for such abnormalities as imperforate anus, imperforate urethra, hypospadias, or epispadias. Failure to recognize these anomalies may greatly interfere with the progress of the infant.

BIBLIOGRAPHY

1. Bonar, Barnet E.: Common Disorders of the Newborn, J. Pediat. 7:362 (Sept.) 1935.
2. Farber, Sidney, and Sweet, Lewis K.: Amniotic Sac Contents in the Lungs of Infants, Am. J. Dis. Child. 42:1372 (Dec.) 1931.
3. Eastman, N. J.: Foetal Blood Studies, Bull. Johns Hopkins Hosp. 47:221 (Dec.) 1930.
4. Henderson, Yandell: The Prevention and Treatment of Asphyxia in the New-Born, J. A. M. A. 90:583 (Feb. 25) 1928.
5. Dunham, Ethel C.: Atelectasis in the New-Born, Am. J. Dis. Child. 43:594 (March) 1932.
6. Grossman, Arthur M.: Coagulation Defects in Infancy and Childhood, J. Pediat. 19:205 (Aug.) 1941.
7. Snelling, C. E.: Vitamin K in Hemorrhagic Disease of the Newborn Infant, J. Pediat. 17:615 (Nov.) 1940.
8. Kove, Simon, and Siegel, Henry: Prothrombin in the Newborn Infant, J. Pediat. 18:764 (June) 1941.
9. Hellman, L. M.; Moore, W. T., and Shettles, L. B.: Factors Influencing Plasma Prothrombin in the Newborn Infant, Bull. Johns Hopkins Hosp. 66:379 (Nov.) 1940.
10. Kove, Simon and Siegel, Henry: Prothrombin in the Newborn Infant, J. Pediat. 17:448 (Oct.) 1940.
11. Cole, W. C. C.: Asphyxia During Delivery and Immediately Post Partum, J. Pediat. 19:263 (Aug.) 1941.
12. Waddell, W. W., Jr., and McL. Lawson, George: Hemorrhagic Diathesis of the Newborn, J. A. M. A. 115:1416 (Oct. 26) 1940.
13. Poncher, H. G., and Katsuji, Kato: Treatment of Hypoprothrombinemia Haemorrhagica Neonatorum, J. A. M. A. 115:14 (July 6) 1940.
14. Quick, A. J., and Seevers, M. H.: Prevention of Bleeding in the Newborn, Wisconsin M. J. 40:581 (July) 1941.

Leptospira Icterohaemorrhagiae*

(WEIL'S DISEASE)

A Study of the First Reported Case in Wisconsin

By JACOB M. FINE, M. B.,** and WARREN J. CONEN, M. D.

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A CASE of Weil's disease is being presented in view of the rarity of this condition in the United States and is, we believe, the first from Wisconsin. The case is further interesting because of the confusion resulting from misinterpretation of signs and symptoms following the administration of drugs of the sulfonamide group. The diagnosis was suggested by the patient's occupation, that of a meat-packing plant laborer, and confirmed by the clinical laboratory. The question arises as to its compensability.

A white male, age 27, became ill about January 1, 1941. The onset was sudden, with chills, fever, severe headache, and cramping pains in the legs. When he was first seen by a physician, a diagnosis of grippe was made. Since the symptoms did not improve, and because he began to cough and râles were heard in the chest, sulfapyradine was prescribed. His condition became worse. On January 5, in addition to the above symptoms, he complained of an unremitting severe frontal headache, nausea, and persistent vomiting. Constipation and abdominal cramps were also present.

The patient looked very ill; his temperature was 104 F., and he was somewhat delirious. There was

* Presented before the monthly staff meeting of Mount Sinai Hospital, Milwaukee, April, 1941.

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slight rigidity of the neck. The conjunctivae were injected. Herpes covered the upper lip. The tongue was dry and furred, and the pharynx was red. The heart was rapid, but the sounds were good. Consolidation was not present, but there were many scattered fine râles in both lungs posteriorly. The abdomen was slightly distended, but the solid viscera were not palpable. Knee reflexes were present. Kernig's and Brudzinski's signs were absent. Hospitalization was advised, and the entrance diagnosis was a bilateral bronchopneumonia (influenza), toxic encephalitis, and vomiting due to sulfapyridine administration.

Intravenous fluids were ordered, and medication was changed to sulfathiazole. The vomiting and headache continued in spite of sedatives. The temperature fell to 100 F. A blood count showed hemoglobin, 14½ Gm., WBC 11,950, and 87 per cent polymorphs, with a shift to the left.

Progressive Symptoms Following Onset

On January 6, five days after the onset, he became icteric; the index was 43. Sulfathiazole was discontinued, and fluids were forced parenterally. The next day the jaundice became more intense. A hemorrhagic tendency developed. Epistaxis was severe enough to demand packing. The herpetic lesions were replaced by crusts of blood. The gums were spongy and bled on the slightest manipulation. Petechial showers developed after a Rumpel–Leede's test. Purpura appeared over the chest and abdomen. The coagulation and bleeding times were three and ten minutes, respectively. The white blood count was 18,500, with anisocytosis, poikilocytosis, and toxic granulation. The blood platelets were 75,000. There was an increased fragility of the RBC's. The urine contained bile and urobilinogen, albumen, RBC's, WBC's casts, but no leucine or tyrosine crystals.

In spite of a lowering of the temperature and pulse rate, the patient continued to be gravely ill. The vomiting persisted. The liver by percussion seemed smaller; the abdomen was distended. The diagnosis was now acute yellow atrophy of the liver, hemolytic anemia, and toxic purpura due to drug administration.

On January 9, the icteric index increased to 105, the urine became dark red to black in color, and hemoglobinuria was suspected. He continued to vomit. A prothrombin time of 60 per cent of normal was obtained at this time. On this day, he developed severe pain in the precordial region, and a pericardial friction rub was heard.

The icteric index was 148 on January 11, and the blood nonprotein nitrogen was 134 mg. with 5.6 mg. of creatinine. The blood pressure rose from 110/80 on entrance to 140/90 with the appearance of azotemia. Weil's disease was now suspected.

Blood and Urinary Tests

A sample of the patient's blood was sent to the National Institute of Health in Washington to determine the presence of agglutinating bodies. Samples of blood and urinary sediment were injected into guinea pigs. Ten days later, the guinea pigs inoculated with urinary sediment, but not those with the blood, became sick and jaundiced and died. These were autopsied, and hemorrhagic areas were found in the lungs, liver, kidney, and spleen. Spread preparations from the heart's blood and from the organs showed many spirochetes, typical in morphology to the Leptospira icterohaemorrhagiae. Sections of the liver stained by the Levaditi method demonstrated the organisms. Blood obtained from these guinea pigs was injected into other guinea pigs which developed the same symptoms, died as had the others, and exhibited similar pathologic findings. Reporting to us that the patient's serum agglutinated the Leptospira icterohaemorrhagiae in a 1:100,000 dilution, the National Institute of Health further clinched the diagnosis.

On January 16, there was a return of the pericardial friction rub and pain in the precordium for a day. Following this, the patient began to improve. The N.P.N. dropped progressively, but on February 4 it rose to 56 mg. per 100 cc. of blood.

Treatment

The treatment was supportive and consisted of daily intravenous injections of 3,000 to 4,000 cc. of glucose in distilled water or saline as an aid to the liver to combat the anemia, and plasma transfusions to replace the drop in the serum proteins. Calcium gluconate, liver extract, vitamin K (Kayquinone), and vitamin C were administered daily. These were administered empirically with the hope of preventing and correcting liver and capillary damage. Bismuth in the form of thiobismol was also administered at four day intervals after the diagnosis was made. We were unable to judge its value.

After Effects

A roentgenogram of the chest taken a week after admission and twelve days after onset showed infiltration of the right lower base compatible with a resolving pneumonic process. He was dismissed from the hospital fifty-three days after admission, with considerable weakness, a moderate secondary anemia, some kidney damage, icterus, a loss of weight of over sixty pounds, and a marked loss of hair.

Proving Weil's Disease

Weil's disease was proven then as follows:

1. By obtaining the organisms from guinea pigs which had been inoculated with the urinary sediment of the patient.
2. By the demonstration of the organisms in the stained tissues of the infected guinea pig.
3. By the high agglutinating power of the patient's serum, 1:100,000, to a known culture of the Leptospira icterohaemorrhagiae. This reaction is as accurate and specific as the Widal reaction in typhoid fever.

4. As a further proof, by capturing four rats at the patient's place of employment and sending them to the National Institute of Health in Washington. One of these had agglutinins in its blood, and the organisms were visible microscopically in large numbers in the kidneys. Spirochetes were also cultured from the kidneys.

In 1886, Weil[1] described the syndrome which bears his name as an entity characterized by an abrupt onset of fever, prostration, muscular pains, jaundice, hemorrhagic tendencies and renal involvement. The causative organism, a Leptospira, was first isolated by Inada and Ido[2] in 1915 from cases in Japan and was named Leptospira icterohaemorrhagiae by Noguchi[3] in 1918. He successfully cultivated these organisms, which he had obtained from American wild rats.

It has been estimated[5] that 4 to 30 per cent of the wild rats in the United States and 10 per cent of all the rats in the world are carriers of the Leptospira icterohaemorrhagiae. The rats do not appear to suffer from the infection, which remains latent in them. The organisms concentrate in the tubules of the kidneys. Mice and dogs are sometimes affected. The urinary excrement contaminates water, food, or soil. Rat infestation of places of work, trenches during wars, bathing ponds, or drinking water fonts form the major sources of the disease.[5]

Weil's disease has been reported as having occurred after a rat bite, the handling of a culture of the organisms, and an infection through a break in the skin.[6, 7]

A questionable epidemic occurred in St. Louis through a holy water font.[7] Another outbreak occurred near Philadelphia from a bathing pond infested with rats.[8] It is not always necessary to have a break in the skin, as guinea pigs may acquire it by the application of infected urine to healthy skin. Van Thiel[9] of the Netherlands emphasizes this. He claims that the disease may sometimes be acquired by swallowing contaminated water, but it is easier for the organisms to enter through the nasal mucosa and conjunctivae. Therefore, it is extremely hazardous for swimmers to snuff water up their noses.

The types of workers frequently mentioned who have acquired this infection are sewer, slaughterhouse, and rice field workers, fish-cutters, and miners. In our case, that of a meat-packing plant worker, it was believed that the organism entered through the abraded skin of his hands, either when he handled materials about the plant or when he tore apart bundles of hay which had been soiled by rat urine.

Pathology

Because a spirochetal septicemia is present in Weil's disease, all organs are affected. However, the liver, kidneys, skeletal muscles, and the capillaries bear the brunt of the invasion.[5]

The liver is usually enlarged, deep yellow in color, and fairly firm. The liver cords are disrupted. Individual cells are separated from one another with some undergoing degeneration. There is stasis in the biliary capillaries and collections of leucocytes, lymphocytes, and fibroblasts near the portal area.

The renal lesions consist of cloudy swelling. The glomeruli may show degeneration, but the tubules are more severely injured. The cells are severely damaged or become completely necrotic. The interstitial tissues are edematous and infiltrated with leucocytes and lymphocytes. Hemorrhages may occur within and between the tubules.

The skeletal muscles, especially those of the calf, present areas of necrosis and hyaline degeneration.

The capillaries are thought to be damaged by the toxins of the spirochete. This is evidenced by the hemorrhages in the various organs and tissues. The hemorrhagic diathesis is also thought to be due to damage of platelet-forming tissues in the bone marrow.[10]

Course

The clinical features of the disease will vary somewhat in different localities, apparently because of the difference in virulence of the infectious agent and the resistance of the patient. Inada[2] divided the disease in its more severe form into three stages: the febrile, icteric, and convalescent.

The febrile stage follows an incubation period of a week to ten days. Its onset is

sudden and is ushered in with a chill, marked prostration and high fever, which may reach 105 F. Meningeal irritation may manifest itself by severe and intractable headaches, delirium, vomiting, stiffness of the neck, and the presence of a Kernig's sign. There are no specific changes in the spinal fluid. It usually is under slight pressure, contains a few cells, and shows some increase in globulin. However, spirochetes have been found in the spinal fluid; indeed, meningitis may be the only manifestation of a Weil infection.[12] Conjunctivitis and herpes labialis appear. Muscular involvement is demonstrated by the marked pain in the back and stiffness and soreness of all extremities, especially the calves. Gastrointestinal disturbances are noted by vomiting, constipation, and abdominal pain. Sore throat, cough, and lung findings, such as râles, may be present. A pulmonary form has been described.[13] Kidney irritation is shown by the presence of albumen, RBC's, WBC's, granular casts in the urine and sometimes in the blood by nitrogenous retention. The blood shows a leucocytosis from 10,000 to 25,000, and the spirochetes can be found in the blood early in the disease. However, this latter finding is very unusual, as the infection is very rarely suspected in this stage. Inoculation of blood into guinea pigs will reproduce the disease. Antibodies to any marked degree have as yet not been developed, and Leptospira are usually not demonstrable in the urine. Death rarely occurs during this time, which covers a period of about five to seven days.

The icteric or toxic stage also lasts about a week. Jaundice appears in 50 per cent of the cases and becomes deeper. The icteric index reached a maximum of 154 in our case. Hemorrhagic tendencies appear with epistaxis, hemorrhagic herpes, subconjunctival hemorrhages, gingival bleeding, purpura, hematuria, hematemesis, and hemoptysis. In our case, the presence of a pericardial friction rub on two occasions probably denoted hemorrhagic involvement of the pericardial surfaces. The liver usually becomes enlarged; the spleen, rarely. The abdomen may show distention. The fever is not usually high and varies between 100 F. and 102 F. Nitrogen retention increases. The blood urea may go as high as 350 mg., accompanied by oliguria and anuria. Death occurs mainly during this period and results from toxemia, dehydration, cardiac insufficiency, and uremia. As the antibodies which begin to form on the fifth day increase, the organisms disappear from the blood stream and can be found in the urine. Injection of the urinary sediment into guinea pigs will reproduce the disease.

The convalescent stage begins after the second week and may be protracted for three to four months, depending upon the severity of the infection. Mental depression is not uncommon. Anemia and weight loss are noted. The improvement in liver function is manifested by its recession in size, a decrease in the jaundice, and the results of the various laboratory tests. The kidneys share, likewise, by their increase in output and the fall in blood nonprotein nitrogen. The fever decreases, but there may be bouts of so-called after-fever, which Inada believes may be due to the absorption of lysed spirochetes or their products. This may be accompanied by an increase in the blood N.P.N. as in our case. There may be a loss of hair. Antibody production reaches its peak about the twenty-fifth day. The spirochetes are abundant in the urine, though they begin to decrease and disappear from the urine in forty to sixty days.

Prognosis

The mortality rate varies from 5 to 50 per cent. Inada in Japan found it to be about 30 per cent. Weil's disease without jaundice is relatively benign.

Diagnosis

In view of the increasing spread of Weil's disease, it is, therefore, important to establish the diagnosis at the beginning of the affection so that specific treatment may be instituted. Unless the disease is epidemic, it is almost impossible to diagnose it at the onset. However, as a result of more refined methods in serology, cases have been diagnosed without or before the appearance of jaundice. It would be futile to mention a list of the diseases which this infection resembles, because of the variability of the clinical picture. Suffice to say, if given a pic-

ture of an acute onset with cramping muscular pains, hemorrhagic diathesis, enlargement of the liver and jaundice, one should suspect this disease. Weil's disease should be considered in every case of unexplained jaundice.

It is the laboratory which confirms and substantiates the clinical findings. This may be done by the following:

1. Demonstrating the organism in a dark field examination of the blood and urinary sediment.
2. The presence of specific agglutinating bodies in the blood serum and even in the urine for the Leptospira icterohaemorrhagiae. This reaction has been obtained even twenty-two years after the original illness.
3. Guinea-pig inoculation of the patient's blood or urine and recovery of the spirochete from its blood and organs by blood smears, and by further transmission to other animals.
4. Tissue stains (Levaditi) demonstrating the spirochete in the liver, kidney, and spleen (of guinea-pigs).
5. Culture of the organism from the blood, urine, or tissues in suitable media.

As for demonstrating the various Leptospira, this may be done by more complicated laboratory procedures.

Treatment

Prophylactic

1. Rats should be eradicated, inasmuch as they are the carriers. This is done by rat-proofing of buildings, traps, etc.[14]

2. By the improvement in hygienic conditions in mines, fields, and fish houses[15, 16] where the disease is endemic, and better care of reservoirs and swimming pools where rats may cause contamination.

3. The wearing of suitable clothing and other protection against skin infections[15] in those who by necessity must work in infected places, e.g., sewers.[16]

Specific

The use of vaccine made from killed cultures of the organism where the disease is endemic has been found to be efficacious. The immune horse and goat serum may be administered during the disease but must be given early, as with all sera, because the spirochete disappears from the blood. The usual dose is 40 to 60 cc. repeated in four to six hours. This serum, however, is not generally available in this country, but it has been used in Hawaii[14] with favorable results. Because human convalescent serum may remain active for as long as twenty-two years[6], it is wise to record the whereabouts of those who have been afflicted. The arsenics have not been found to be of great benefit. Bismuth is of some use, and, as this was given in our case, it may have contributed to recovery. Supportive therapy has been previously mentioned.

Recovery from Weil's disease, unlike other spirochetal infections, confers a definite and lasting immunity.

Legal Aspects

As has previously been mentioned, certain occupations are particularly subject to this affection, and this varies directly with the amount of rat infestation and the chances of contamination. Fairley's work in England[15] showed that Weil's disease was particularly prevalent among sewer workers in London and had hitherto been unsuspected. In Aberdeen[17] an illness known as fish cutter's disease was also proven to be due to leptospirosis icterohaemorrhagic when blood specimens taken from workers contained specific agglutinins in high titers. As a result, Weil's disease was listed as an industrial disease under the Workmen's Compensation Act of Great Britain. Legal precedent had already been established there in 1925 when compensation was awarded for the death of a coal miner, and the award was upheld following an appeal. (Raeburn vs. Lochgelly Iron and Coal Co., Ltd., 20 B. W. C. C. 637.)[18-20]

In New York City in 1938,[19] compensation was claimed on behalf of a fish worker under the Workmen's Compensation Act of New York State. In a hearing, it was held that the claimant had established that the infection had arisen from an accident in the course of his employment, and an award was

made in his favor. Compensation was also granted in March, 1939, to a Manhattan fish-cutter who developed an "illness resembling Weil's disease, whose blood serum showed specific immune properties against Leptospira icterohemorrhagiae." About this time, a fatal case occurred in a Buffalo fish merchant which seemed to justify that this disease was an industrial hazard.

Conclusion

An editorial in the *Journal of the American Medical Association* in 1934[21] stated that this disease was far more prevalent than was suspected and was "fated to play an ever larger part in medicine and public health." Another editorial commenting in a similar vein appeared in the same journal of October, 1937,[22] and said that "Failure to recognize the disease probably accounts for the report of so few cases in the United States."

Summary

A case of Weil's disease in an abattoir worker has been presented and proven by bacteriologic, immunologic, and rodent study. With the newer advances in chemotherapy and the temptation to use these drugs in undiagnosed fevers of a few days' duration, care must be taken not to confuse this disease with their toxic manifestations.

The occupational and public health hazard has been discussed, and the prevention of this disease has been shown to depend upon the efficiency of rodent control.

Note

Since this paper was written, a very extensive review of Weil's Disease appeared in Medicine, May 1941, by Wm. F. Asche, etc., with a review of the American and an abstract of the World literature.

Eighteen months after the inception of his illness, our patient is still disabled. He has:

1. Severe and disabling root pains along the lower cervical and upper thoracic nerves with atrophy of the left deltoid muscle. Roentgenography of spine and spinal fluid were negative.

2. Dyspnea on exertion, a pulse rate of 90 to 100, with a diminished vital capacity. Electrocardiogram, basal metabolic rate, and roentgenogram of the heart and lungs were normal.

Therapy of every conceivable nature has been of no avail. This case is unique, as these complications are not noted in the above monograph.

Acknowledgment

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BIBLIOGRAPHY

1. Weil: Deutsch, Arch., f. klin. Med. 39:209, 1886.
2. Inada, R., and others: The Etiology, Mode of Infection, and Specific Therapy of Weil's Disease (Spirochetosis Icterohemorrhagica), J. Exper. Med. 23:377 (Mar. 1) 1916.
3. Noguchi, Hideyo: Spirochaeta Icterohaemorrhagiae in American Wild Rats and Its Relation to the Japanese and European Strains, J. Exper. Med. 25:755 (May 1) 1917.
4. Packchanian, A.: Ictero-Hemorrhagic Spirochetosis in the United States, Bull. de l'office Internat. d'hygiene publique, Paris 29:2350 (Nov.) 1937.
5. Hascher, W., and Tobey, Franklin: A Case of Weil's Disease, J. A. M. A. 113:1319 (Sept. 30) 1939.
6. Gaines, A. R., and Johnson, R. P.: Weil's Disease, Report of Seven Cases, Arch. Int. Med. 60:817 (Nov.) 1937.
7. Willett, J. C.: Sigloff, E., and Pfau, C. L.: An Institutional Outbreak of Epidemic Jaundice, J. A. M. A. 106:1644 (May 9) 1936.
8. Havens, W. P.; Bucher, C. J., and Riemann, H. A.: Leptospirosis: A Public Health Hazard, J. A. M. A. 116:289 (Jan. 25) 1941.
9. Van Thiel: Nederlandsch Tydschrift voor Geneeskunde; abstracted, J. A. M. A. 104:1838 (May 18) 1935.
10. Naegeli, Otto: Differential Diagnosis in Internal Medicine, Authorized Translation by S. B. Spilberg, Chicago, S. B. Debour, 1940.
11. Walch, Sorgdrager: Leptospirosis, Bull. of Health, Org. League of Nations, Geneva, 8:143.
12. Mortonson, Vagn: Nervous Complications of Weil's Disease, Lancet 238:117 (Jan. 20) 1940.
13. Wohwill, F.: Pulmonary Form of Weil's Disease, Lisbon Med. 16:229 (April) 1939.
14. Tokuyama, Seigo: Weil's Disease (Leptospira Icterohaemorrhagiae) in Hawaii, J. A. M. A. 114:2195 (June 1) 1940.
15. Fairley, N. H.: Weil's Disease among Sewer Workers in London, Brit. M. J. 2:10 (July 7) 1934.
16. Davidson, L. S. P.: New Occupational Disease in Fish Workers, Glasgow Med. J. 11:113 (March) 1938.
17. Davidson, L. S. P., and Smith, J.: Weil's Disease in Fish-Workers: A Clinical, Chemical, and Bacteriological Study of Forty Cases, Quart. J. Med. 5:263 (April) 1936.
18. Editorial: Compensation for Weil's Disease, Brit. M. J. 1:1081 (May 25) 1935.
19. Farrell, Elliston: Weil's Disease, New York State J. Med. 39:1969 (Oct.) 1939.
20. Glotzer, Solomon: Weil's Disease, J. A. M. A. 110:2143 (June 25) 1938.
21. Editorial: Spirochetal Jaundice in Sewer Workers, J. A. M. A. 103:493 (Aug. 18) 1934.
22. Editorial: Spirochetal Jaundice, J. A. M. A. 109: 1128 (Oct. 2) 1937.

Mumps Followed by Orchitis and Meningitis

A Case Report

By VINCENT W. KOCH, M. D.
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Condition on Admission

The patient, a white male, age 18, entered the hospital on March 28, 1941, in an ambulance. He had abdominal pain, tenderness over McBurney's point, a headache, cough, and a temperature of 104.8 F.

History of Present Illness

Patient had had the mumps. Orchitis followed. Bilateral hydrocele resulted. Patient then developed abdominal pain, cough, headache and temperature of 104.8 F., at which time he entered the hospital.

Past Medical History

The patient has always had very poor vision. Before admission he had been a student at the Wisconsin State School for the Blind.

Physical Examination

He appeared feverish and prostrated at time of examination.

Skin was hot and moist. His face was flushed. There was tenderness over the entire head, associated with the headache.

His eyesight was very poor. He could barely distinguish fingers placed in front of him.

His tongue was coated. The throat was injected. Tonsils were hypertrophied. There was tenderness over the parotid glands.

Breathing was rapid and shallow. There was stiffness of the neck. There was impaired resonance in the right lower base; also soft râles.

Examination of the heart revealed no pathology. The blood pressure was 136/84; pulse 108.

There was generalized tenderness over the abdomen. There was pain in the back on passive movement of it. There was bilateral hydrocele.

Laboratory Data

Spinal Fluid—March 29, 1941.
Fluid clear under normal pressure.
Cell count—83. High per cent of lymphocytes.
Sugar—80 mg. per cent.
Gram stain showed no organisms.
Globulin—positive.
Culture showed no growth after forty-eight hours incubation.
Wassermann—negative.
Gold sol—000 000 000.
Total proteins—34 mg. per cent.

March 30, 1941.
Spinal fluid—slightly under pressure and clear.
Cell Count—60.
Sugar—65 mg. per cent.

April 2, 1941.
Spinal fluid—very little pressure and clear.
Cell Count—16.
Sugar—50 mg. per cent.

Hydrocele Fluid—April 7, 1941.

Gram stain showed no organisms. Negative for acid fast bacilli.
Guinea-pig inoculation negative.

Roentgenogram of Chest—March 29, 1941.

Trachea in midline. Some increased density in both bronchial trees.

Clinical Course

The patient, on the day of admission, was very restless, had insomnia and a headache. He refused to eat. Codeine, ½ grain, and nembutal, 1½ grains, were given the first night. He had a temperature of 104.6 F. That night promin was begun, 45 grains, intravenously every four hours, whereupon the temperature began to drop and continued to drop progressively until it reached 98.6 F. after forty-eight hours of administration of promin. During this period he drank a fair amount of water, but refused any food. Four hundred cc. of 20 per cent glucose were given on the second day. A spinal puncture was done on March 29. Fifteen cc. of clear spinal fluid under normal pressure were withdrawn.

His head was repeatedly elevated. He had periods of profuse perspiration, also cyanosis of lips and fingers.

Until April 1, 1941, he had periods of nausea, headaches and anorexia. These disappeared after this date.

His condition improved progressively from day to day, so that he left the hospital ambulatory on April 12.

At the time of his admission to the hospital, the patient's temperature was 104.6 F. RBC count was 4.52 million, WBC 11,200, and Hb 80 per cent. Promin, 270 grains, was administered daily for a course of four consecutive days. The temperature decreased progressively to 103.4 F. on the second day, 101.0 F on the third day, and normal on the fourth day. RBC count at the end of this course of treatment was 4.10 million, WBC 8,000, and Hb 85 per cent. Urinary findings were essentially negative throughout the patient's clinical course.

It is interesting to note that this course of intensive treatment with promin was very

satisfactory in reducing the temperature to normal and was in no way destructive to the blood constituents.

Remarks

This case is of interest because of the complication of mumps, namely, meningitis. When one considers the numerous cases of mumps each year and the relatively infrequent secondary cases of meningitis, one realizes the rarity of this complication. Orchitis following mumps occurs much more frequently, Cecil reporting it to occur in from 15 to 30 per cent of the cases. He states that meningitis as a complication is infrequent, but that in epidemics it has been found to occur in as high as 23 per cent of the cases. Osler also considers it an infrequent complication.

Notes Taken From Material From Consulting Bureau Service

Dr. H. Silwer: Meningitis in Mumps.

1. Clinical symptoms of meningitis occurred in 8 to 10 per cent of cases of mumps.
2. They appeared from one to eleven days after the onset of mumps.
3. No definite connection with orchitis could be discovered.
4. The meningeal symptoms were slight or moderately pronounced, headache and stiffness of the neck being most common.
5. Spinal fluid pressure normal in most cases.
   a. Globulin reactions were negative or slightly positive.
   b. Cells varied from 3 to 920 cubic mm., chiefly mononuclear cells.
   c. Sugar: 72 to 78 mg. per cent.
6. The prognosis was good in all cases.

Dr. T. L. Birnberg: Mumps Meningo-encephalitis.

1. The virus is the causative agent of the meningitis—experimental evidence.
2. Males are attacked more than females, 78:22.
3. Symptoms: headache, vomiting, fever, hiccough, lethargy, or irritability were inconstant.
4. Signs: rigidity of neck, positive Kernig's.
5. Spinal Fluid: clear, pressure slightly increased. Nonne's test usually negative. Cell count 6 to 980, predominately lymphocytes; absence of organisms in fluid.
6. Duration: Three to eleven days, average of six days.
7. Differential diagnosis:
   a. Tuberculous meningitis.
      1. Develops slowly.
      2. Cerebral cry.
      3. Clinical symptoms when fully developed much more severe.
      4. Earlier a higher poly. count in spinal fluid.
      5. Pedicle formation.
      6. Tubercle bacilli.
   b. Poliomyelitis.
      1. Occurs in later summer. Mumps is more prevalent in winter and spring.
      2. Early paralysis and absent reflexes.

Dr. W. R. Larkin: Mumps Meningitis Found at Camp Taylor Base Hospital with Autopsy Findings.

1. Spinal Fluid Characteristics:
   a. Clear.
   b. Cell count average 200, lymphocytes.
   c. Sterile.

Epidemic Keratoconjunctivitis

By EDWIN C. BACH, M. D.*
Milwaukee

AT THE present time there are probably well over 1,000 cases of keratoconjunctivitis in the Milwaukee area. The recognition and suppression of this disease is important because it is the cause of considerable disability. Another important fact is that in the East and also in the Middle West sources of infection in many cases have been definitely traced to first-aid rooms in plants, and to the offices of physicians where the contagiousness of the disease apparently was not appreciated.

The following is a summary of the disease from some of the more recent literature:

Definition

Epidemic keratoconjunctivitis is an acute contagious nonpurulent conjunctivitis usually involving only one eye and characterized by edematous inflammation, regional lymphadenitis, and subsequent appearance of punctate opacities in the cornea.

* From the Department of Otolaryngology, Marquette University School of Medicine.

History and Distribution [1, 2, 7]

Von Reuss, Von Stellwag, Fuchs and Adler first described the disease in 1889, at which time there appeared to be an epidemic of the disease in Austria. Herbert, in 1901, reported the next large epidemic from Bombay. Sporadic cases were reported in 1909 by Wiener and in 1911 by Verhoff and Gradle. Kirkpatric described an extensive epidemic in Madras, India, in 1920. Between May, 1928, and January, 1930, Wright saw 3,500 cases again in Madras. Doggart described 43 cases from London in 1933. In 1941 Viswalingham published the record of 3,500 cases from Malaya. In Germany the disease started in the southwest cities and spread northeastward. Upward of 3,500 cases were reported chiefly during 1938 to 1940. The first epidemic in the United States was reported by Hobson and occurred in a veterans' hospital in San Fernando, California, in 1938. Holmes reported that during the summer of 1941, 10,000 cases occurred in Hawaii. Late in the summer of 1941 the disease appeared on the west coast of the United States. Early in 1942 cases appeared in New York and subsequently in various parts of the United States. Other epidemics have been reported from Tasmania, China and South America.

Etiology [1-5]

1. All races are affected. Epidemics seem to indicate the disease is more prevalent in the fall of the year, reaches a peak in early winter and tapers off toward spring.

2. Occupation has no influence. Epidemics have occurred among agricultural workers and among industrial workers.

3. Individual susceptibility plays an important role. Children below the age of puberty seem to be immune. Males are affected two or three to one female. Injury or inflammation appears to predispose to subsequent infection.

4. Close contact in work seems to favor transmission.

5. The incubation period is from five to twelve days.

6. The causative agent appears to be a virus for the following reasons:

(a) Bacteriologic evidence is negative. Positive findings of earlier investigators could not be substantiated by subsequent experiment.

(b) Wright was able to produce the disease in human volunteers by using filtered sterile material from diseased eyes.

(c) Failure of corneal lesions to ulcerate.

(d) Passage from human to human in absence of bacteriologic findings.

(e) Early rapid involvement of lymphatics and early constitutional symptoms in many cases.

(f) Exudate from conjunctival scrapings are consistently lymphocytic instead of polymorphonuclear.

(g) Experimental work by Sanders indicates isolation of a specific virus. From his culture he was able to produce the disease in a human volunteer.

Titrations of serum from 19 convalescents revealed definite neutralizing antibodies in all cases. Antibody development was demonstrated in 6 patients from whom serum was obtained early and again later after the onset of the disease. All sera showed increase of titer in later samples.

Pathologic Findings [2, 7]

The conjunctival epithelium was found to be infiltrated with lymphocytes. These cells were also scattered diffusely and perivascularly in the subepithelial connective tissue. No bacteria were found and no virus particles seen in the epithelial cells.

Pathologic findings in regard to histologic changes in the cornea are variable. Some investigators report only edema in the superficial lamellae of the cornea. Others report cellular infiltrates. Some report necrotic changes in the epithelium and some necrotic changes just below Bowman's membrane.

Symptoms [1, 2, 4, 5]

The onset is usually sudden with edema appearing in the caruncle and semilunar fold and inferior cul-de-sac. The patient here complains of a sandy feeling. Some hours later the bulbar conjunctiva becomes involved and the whole eye more congested.

There is no discharge, but occasionally a fibrinous exudate appears on the lids.

Mononuclear cells but no causative bacteria are found in smears of conjunctival scrapings.

The preauricular node becomes tender, and some patients complain of headache and malaise.

In eight to fourteen days the conjunctivitis begins to subside and, if the patient be-

gins to complain of blurred vision, punctate opacities of the cornea will be found.

In about 40 per cent the second eye becomes involved, but usually less severely.

Prognosis

The prognosis for return of vision is good, but may take over a year.

Treatment [2, 4, 5]

To date, palliative treatment gives the best results. Strong antiseptics of any kind seem to aggravate the inflammation. The sulfa drugs internally or locally have proven ineffective. Cold compresses, cool saline irrigations, bland ointments and dark glasses give some comfort. Radiation gives no conclusive results. Quinine bisulfate ointment and dionin have been used in an attempt to clear the cornea.

Recommendations [6]

Since the disease is quite contagious, the following precautionary measures are advisable:

1. Isolation of patient for two weeks if practicable.

2. Careful supervision of patients with irritated eyes. Irritation seems to make them more susceptible to the disease.

3. Advice to the patient that the disease is transmissable and he may contaminate towels and other fomites.

4. Thorough washing of hands after examining an infected eye and before examining another patient.

5. Sterilization of solutions, eye droppers and instruments used in eye cases.

BIBLIOGRAPHY

1. de Roetth, Andrew F.: Epidemic Kerotoconjunctivitis, Northwest Med. 41:246 (July) 1942.
2. Hogan, M. J., and Crawford, J. W.: Epidemic Keratoconjunctivitis, Am. J. Ophth. 25:1059 (Sept.) 1942.
3. Sanders, Murray: Epidemic Keratoconjunctivitis ("Shipyard Conjunctivitis"), Arch. Ophth. 28:581 (Oct.) 1942.
4. Sanders, M.: Gulliver, F. D.; Forchheimer, L. L., and Alexander R. C.: Epidemic Keratoconjunctivitis, J. A. M. A. 121:250 (Jan. 23) 1943.
5. Berliner, M. L.: Epidemic Keratoconjunctivitis, Am. J. Ophth. 26:50 (Jan.) 1943.
6. Sanders, Murray: Epidemic Keratoconjunctivitis, J. A. M. A. 121: 598 (Feb. 20) 1943.
7. Duke–Elder, Sir Wm. S.: Text-book of Ophthalmology, St. Louis, The C. V. Mosby Company, 1940, vol. 2, p. 1881.

PEN-LIGHT AND INSTRUMENT BATTERIES

Advice has been received from physicians in various areas in the state that it has been impossible for them to obtain batteries for their pen-light flashlights that are used in illuminating the throat and for use in connection with battery-lighted otoscopes, ophthalmoscopes and similar instruments.

If members of the Society encounter difficulty and find it impossible to obtain batteries locally and if they will advise the Society's office of the size number of the batteries used and the quantities essential to take care of current needs, we will, through priority arrangements, attempt to obtain these needed supplies at the prevailing retail rate. For example—three Number 2 Unit Cell (Ray-O-Vac) or two Number 7R Pen-Light Unit Cells (Ray-O-Vac).

Comments on Treatment

Editors—A. J. QUICK, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Painful Shoulder Syndrome

The shoulder is a common site of pain. The cause may be found in the joint itself, in the bursae, the tendons, the nerves or the muscles. Pain originating in the muscles of the shoulder gives rise to a peculiar syndrome characterized by localized points of tenderness, persistent myalgia of the shoulder girdle and frequently limitation of motion.

It appears that the tender spots are trigger points in the muscles giving rise to pain referred to various parts of the shoulder. The exact mechanism is not understood. There is little evidence that it is inflammatory in origin. It is likely that the pain is the result of a sustained spasm of skeletal musculature. The pain, in turn, causes reflexly further muscle spasm. Thus a vicious cycle is created and maintained. On the basis of this theory, the logical treatment is to relax muscle spasm. This can be accomplished by the intramuscular injection of procaine into the trigger points, i.e., into the localized areas of marked muscle tenderness.

A successful routine of treatment has been outlined by Doctors Travell, Rinzler and Herman.[1] A 1 per cent aqueous solution of procaine hydrochloride without epinephrine is employed. The maximum points of tenderness are located. This can often be best done by putting the muscle on the stretch and by applying strong pressure. The muscle which most frequently causes pain is the serratus posterior superior, and next in frequency as a focus of pain is the infraspinatus.

The exact localization of the trigger points is essential. These are injected with 2 to 5 cc. of the procaine solution. As many focal areas of tenderness should be injected as is consistent with safety. Usually it is advisable not to inject more than 10 to 20 cc. of procaine solution. Occasionally larger doses can be injected, but this depends on the tolerance of the patient. One must remember that certain individuals are extremely sensitive to procaine, and therefore each new patient should be given an initial test dose of 1 to 2 cc. Procaine is rapidly absorbed from muscle, consequently the rate of injection should not exceed 1 cc. per minute. Several injections are usually required. These are conveniently given at weekly intervals, although more frequent injections are permissible.

Relief of both pain and limitation of motion can be obtained in a high percentage of cases. Often the results are spectacular, and sometimes complete relief is obtained after one treatment. If no relief is observed after two or three treatments, one can conclude that the condition is not amenable to procaine therapy.

Before applying the injection treatment, it is essential to make a diagnosis of idiopathic myalgia. Conditions which may simulate this syndrome should be ruled out. Diseases or injuries of the bones and joint are demonstrable by roentgen-ray examination. Subacromial bursitis may present real difficulty in the differential diagnosis, but generally this condition presents signs of inflammation including local swelling. The scalenus anticus syndrome may cause confusion. In this condition pain is present in the upper extremity and neck, signs of venous obstruction may appear and vasomotor changes may occur. Certain neurogenic disorders such as compression of the brachial plexus should also be ruled out.

A. J. Q.

[1] Travell, J.; Rinzler, S., and Herman, M.: Pain and Disability of the Shoulder and Arm, J. A. M. A. 120:417 (Oct. 10) 1942.

The Nation at War

In this section of *The Journal*, to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Army's 1943 Recruiting Program Will Require 6,900 Physicians

Outline of Procedure Reveals None Will Be Commissioned Until Found Available by Procurement and Assignment Service

The 1943 recruiting program of the Surgeon General of the Army calls for the commissioning of 6,900 physicians and approximately 3,000 hospital interns and residents, it is reported in *The Journal of the American Medical Association* for March 13 in an outline of the new procedure of processing physicians, dentists and veterinarians for the Army. The program also calls for the commissioning of 4,800 dentists and 900 veterinarians.

Physicians will be procured from the following twenty states and the District of Columbia: California, Colorado, Connecticut, Illinois, Iowa, Maryland, Massachusetts, Minnesota, Missouri, Nebraska, Nevada, New Hampshire, New Jersey, New York, Ohio, Oregon, Pennsylvania, Rhode Island, Vermont and Wisconsin.

The following states have already contributed more physicians to the armed forces than the sum of their 1942 and 1943 quotas and will not be called on to furnish any more physicians, except interns and residents and except special cases for specific position vacancies, during 1943: Alabama, Arizona, Delaware, Georgia, Idaho, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, South Carolina, Tennessee, Texas, West Virginia and Wyoming.

It is stated that at present there will be no procurement of physicians, except interns and residents and in special cases for specific position vacancies, in those states not listed above. There will be no procurement of dentists, except special cases for specific position vacancies, in the following sixteen states: Alabama, Arizona, Arkansas, Delaware, Florida, Georgia, Kentucky, Louisiana, Mississippi, New Mexico, North Carolina, Oklahoma, South Carolina, Tennessee, Texas and Virginia.

At the present time there are no restrictions on the recruiting of veterinarians.

In the instructions issued by the Army it is pointed out that the Surgeon General has discontinued all medical officer recruiting boards and that under the new procurement program no physician, dentist or veterinarian will be commissioned in the armed forces of the United States until he has been declared "available" by the Procurement and Assignment Service of the War Manpower Commission.

In each state the Procurement and Assignment Service has set up three state chairmen: medical, dental and veterinary. Each of these prepares a monthly quota list of physicians, dentists and veterinarians who are apparently suitable and who are available for commissioning in the Army of the United States. This list is submitted to the central office of the Procurement and Assignment Service which sends a communication inviting such individuals to apply for service with the armed forces. On the reply card enclosed with the invitation the individual states his preference for the Army, Navy or Medical Department of the Air Forces. These reply cards are sent by the potential applicants to the state chairmen of the Procurement and Assignment Service who in turn submit lists of such potential applicants to the Officer Procurement Service of the Army.

On receipt of such lists the officer procurement district office contacts the potential applicant and arranges for an interview regarding a commission.

Applicants will be requested by the officer procurement district office to complete all papers and take all steps required of them within fourteen days of the date of such request. If this is not complied with, a report thereon will be transmitted by the officer procurement district office to the state chairman of the Procurement and Assignment Service.

The decision as to the grade and appointment to be recommended for each candidate rests with the Surgeon General, not with the Officer Procurement Service.

Journal of the American Medical Association Says Physicians Must Volunteer from Larger Cities

Declares That Young Available Doctors Who Fail to Do So Should Be Brought Before the Bar of Public Opinion

Young available physicians in the large cities of the country, particularly in those of the eastern seaboard, whose failure to volunteer has caused a lag in the procurement of medical officers for the armed forces, should be called before the bar of public opinion, *The Journal of the American Medical Association* for March 27 declares in an editorial. *The Journal* says:

"At a recent meeting in Washington of the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians with the Officer Procurement Service of the United States Army and with representatives of other governmental agencies, evidence was clearly set forth that the procurement of medical officers for the armed forces is lagging. The responsibility rests unquestionably on the failure of young available physicians in the large cities of the country, particularly those of the eastern seaboard, to volunteer. Officers of the medical societies of New York, Massachusetts and Connecticut were present and the situation was placed before them. The rural areas of the United States have contributed doctors not only up to such quotas as were assigned to them but in many instances well beyond these quotas; it is simply impossible to anticipate that they will make a further contribution at this time. In the meantime, New York, Brooklyn, Boston and some of the larger communities in the states of Connecticut, New Jersey, Pennsylvania and California have failed even to approximate their quotas.

"The needs of the armed forces for physicians during 1943 are well defined. The number of physicians to be expected from recent graduates, interns and those now holding residencies has been determined. Beyond this number at least six thousand more physicians must come from the civilian population. The Procurement and Assignment Service for Physicians, Dentists and Veterinarians has devised a technic which involves, first, a determination of the availability of the physician concerned or his essentiality for any civilian position which he occupies; second, notification of the physician of his availability and a request that he appear before his local procurement board; third, a notification of the Selective Service Board of the fact that the physician concerned is considered available and that he has failed to volunteer. Thus far pressure beyond this has not been exercised. There remains, however, the mobilization of the pressure of public opinion.

"In some instances physicians have declared flatly to representatives of the Procurement and Assignment Service and the Officer Procurement Service that they do not wish to volunteer and that they will not volunteer. When it is known to other physicians in the community that a physician under 38 years of age, declared available by the Procurement and Assignment Service, refuses to volunteer in this time of the nation's need, when many an older physician, frequently with innumerable obligations, has given up his home, his practice and the responsibilities of years to participate in this war, the public has a right to know that the younger physician is not willing to do his part. Certainly the Procurement and Assignment Service should consider the possibility at this advanced stage of the war effort of making public through the state medical journals not only the names of those who are already participating in the war but also the names of those who have been declared available and have not themselves

ever indicated a willingness to participate. Let them be called before the bar of public opinion!"

Duties of United States Citizens Defense Corps in Gas Defense

A program for civilian protection against gas is being rapidly developed by the Medical Division of the Office of Civilian Defense. Courses have been presented for physicians, selected from the faculties of medical schools, to be trained as instructors in the medical aspects of chemical warfare. Arrangements are now being made for the presentation of courses by these instructors in their own medical schools.

Training for nonmedical personnel is provided in Gas Specialist Courses which since early December have been presented monthly at War Department Civilian Protection Schools. These schools are located at Amherst College, Amherst, Massachusetts; Purdue University, Lafayette, Indiana; Loyola University, New Orleans, Louisiana; Occidental College, Los Angeles, California; Stanford University, Palo Alto, California, and the University of Washington, Seattle, Washington.

The Gas Protection Service of the United States Citizens Defense Corps has been organized as follows: The Medical Division of the Office of Civilian Defense has a Gas Protection Section responsible for organization and training for gas defense. This section functions through the nine Civilian Defense Regions, which are coterminous with the Service Commands of the United States Army. Regional Gas Officers have been designated for several of the coastal regions to supervise and assist the State Gas Consultants and the Senior Gas Officers of defense councils in the organization of state and local programs. The Senior Gas Officer trains Gas Reconnaissance Agents who serve in each zone of the city. These men are responsible for the identification of the agent, the collection of samples, the prevention of casualties, the delimiting of gassed areas, and for cooperation with the Emergency Medical Service, the Health Department and other agencies concerned in protection against gas.

Instructions to members of the United States Citizens Defense Corps on their duties in gas defense have been issued by the United States Office of Civilian Defense in Operations Letter No. 104 (Supplement 3 to Operations Letter No. 42), dated January 11.

The duties to be performed before, during and after gas attacks are outlined for the following individuals and groups: State Gas Consultant, Senior Gas Officer, Assistant Gas Officers, Gas Reconnaissance Agents, Laundry Officer, Commander of the Citizens Defense Corps, Incident Officer, Air Raid Wardens, Police Services, Fire Services, Emergency Medical Service, local Health Department, Public Works, Public Utilities, Transportation Services and Emergency Welfare Services.

Physicians interested in details of the various duties outlined above may obtain same by communicating with the secretary's office of the State Medical Society.

Medical Society of Milwaukee County Appoints War Mobilization Committee

"Following the policy adopted by the House of Delegates of the American Medical Association meeting in Atlantic City last June, the chairman of the Council of the State Medical Society of Wisconsin appointed the Committee on War Participation composed of three sub-committees to be in charge of Procurement and Assignment, Replacements and Civilian Defense.

"To guarantee the cooperation of the Medical Society of Milwaukee County with these committees, the Medical Society set up the War Mobilization Committee which was designed to advise authorities on the availability and essentiality of physicians, to assure the smooth functioning of draft boards, to protect the industrial and civilian health of the community, to prevent the drafting of medical and pre-medical students, and to insure adequate medical care for soldiers and civilians alike by careful distribution of available physicians.

"In organizing this new committee, the Board recognized the fact that during these days of rapid change in regulations and policies, it is vitally necessary that good reciprocal cooperation exist between the executive groups and officials in both county and state.

"As a result, meetings have been held with the committee appointed by the Procurement and Assignment officer and the Board of Directors of the Milwaukee County Medical Society. Especially does the Board wish to stress its unqualified approval of the meeting held for the purpose of explaining the present military status of all available men under 38 years of age.

"It is the sincere hope that in spite of national confusion, everything possible will be done to reach the goal of a supply of an adequate number of physicians for both the armed forces and the civilian population without any undue complication"—CAREY, EBEN J.: *The Presidents Message, Milwaukee Medical Times (March) 1943.*

Military Notes

Captain Albert N. Tousignant, Oconto physician, has been officially reported a prisoner of war in the Philippine islands, ending a year of uncertainty about his fate when the area was taken by the Japanese. His wife was informed in an official War department message on March 17 that he was being held prisoner by the Japanese.

The doctor left for Manila May 21, 1941, and became assistant chief surgeon at the Sternberg hospital in Manila. His wife last heard from him in February, 1942, and he was reported missing after the fall of Bataan and Corregidor.

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Lieutenant John S. Giffin, M. C., formerly of Oconomowoc, writes that he now is located at the Station Hospital, Keesler Field, Mississippi, having graduated from the Miami Beach Officers Training School Army Air Forces on January 9.

—△—

Lieutenant Commander Joseph J. Grimm, formerly of Milwaukee, has reported for active duty in the United States Navy. He is located at the Sampson Base Naval Training Station at Geneva, New York.

—△—

Lieutenant Ray G. Piaskoski writes that he appreciates receiving *The Journal* each month and that it is interesting to read about the location and activities of other Wisconsin men. As chief of the physical therapy section, he is located at the Nichols General Hospital, Louisville, Kentucky. Lieutenant Piaskoski's home is Milwaukee.

HEADQUARTERS
NINTH NAVAL DISTRICT
GREAT LAKES, ILLINOIS

LIEUTENANT COMMANDER
ROGER Q. WHITE

Great Lakes, Illinois, March 24—Commander Everett B. Keck, Medical Corps, USNR, former Madison physician and surgeon, has been awarded the Silver Star Medal for gallantry by President Roosevelt it was announced here today.

Commander Keck, whose home address is 1 West Main Street, Madison, was in command of a medical battalion in the Guadalcanal area of the Solomon Islands during the six weeks of heavy fighting from early August until mid-September.

The citation for the 49-year-old Commander, as released for the President by Secretary of the Navy Frank Knox, read as follows: "For extremely gallant and intrepid conduct as Commander of E Company, First Medical Battalion, in Guadalcanal Area, Solomon Islands during the period August 7 to September 24, 1942. Rendering invaluable service by the consistently high degree of morale and efficiency in his command in the face of repeated enemy bombing and shelling raids, Commander Keck, in addition, coolly and skillfully performed numerous surgical operations for the care and relief of those wounded in battle."

Dr. Edward J. Kiefer, Milwaukee, of the Medical Corps of the Naval Reserve, is at present stationed with the Acorn Training Detachment, Port Hueneme, California.

—△—

A letter from Lieutenant Fred S. Marshall indicates a recent change in location to the Station Hospital, Camp Breckinridge, Kentucky. Lieutenant Marshall, formerly of Black Earth, was resident surgeon at the Shriner Hospital for Crippled Children, Chicago, for over a year prior to his induction.

—△—

Lieutenant Weston J. Schutz, Shawano, writes that he entered service August 4, has since attended the School of Aviation Medicine at Randolph Field,

Texas, and is now with the Army Air Forces in the Flight Surgeon's Office of the Station Hospital at Kearns Field, Utah.

He says, "I enjoy bragging about Wisconsin medicine in discussions with physicians from all over these United States. I know our State Society will continue to keep firm through these troubled times."

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From Camp Barkeley, Texas, Captain David F. Cole writes as follows: "Your letter of March 4 was gratefully received. It is a pleasure to show the fine spirit of your society to M. D.'s from other states and find out Wisconsin is pioneering in another field. We men are proud to be able to help wherever we can in fighting and winning this war." Captain Cole formerly practiced at Ripon.

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Acquainting us with his change of address from El Paso to the Office of the Camp Surgeon, Mexia Internment Camp, Mexia, Texas, Lieutenant Colonel Walter A. Ford, formerly of the Sheboygan Clinic, Sheboygan, describes his assignment as follows: "The Camp, as the name implies, is for the confinement of internees or prisoners of war. We rather expect the latter to be sent to us. As this is a new camp and incomplete, no prisoners have as yet been received.

"There is a new 150 bed Station Hospital here, and it is very nearly ready to be activated, at which time, instead of a Camp Infirmary, we will call it the Station Hospital. My job is Camp Surgeon and Commanding Officer of the Hospital."

—△—

Captain Robert J. Reuter, formerly of the Department of Dermatology at the Jackson Clinic, Madison, writes that he enjoyed the "news letter" and hopes to receive a similar communication again. Captain Reuter is located at the Station Hospital of the Army Air Base, Hammer Field, Fresno, California.

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From San Antonio, Texas, Lieutenant Joseph F. Kelley writes that he does not see any Wisconsin men at his location except for a few who have taken some special courses at Wisconsin General Hospital, Madison, or who have been in attendance at the Radio School, Truax Field. He adds, "I must tell you that the preparation we see here is not planned for any Axis good." Lieutenant Kelley formerly practiced at Janesville.

TUBERCULOSIS IN THE ARMED FORCES AND THE CIVILIAN POPULATION

The cost of tuberculosis among World War I veterans has passed the billion dollar mark. To forestall similar expenses after this war the armed forces are determined to keep tuberculosis out of the services. By the spring of 1942 sufficient roentgen ray equipment was made available to give every inductee a chest roentgenogram. Rejection for tuberculosis has been about one out of every 100 draftees thus examined. This means that 100,000 cases of tuberculosis will have been turned back into civilian life, should we create an army of 10,000,000 men.

Early finding and diagnosing of *all* cases of tuberculosis is the foundation of tuberculosis control. Selectees are only a few millions of the population. What about the other millions of men, either too young or too old for service in the armed forces, and the 40,000,000 women who are serving their country as workers or homemakers? They too may have tuberculosis. An example has been set by the armed forces. Routine roentgenography of the chests of apparently healthy people for the purpose of finding the disease is now an accepted practice at induction centers. It should become an accepted practice in civilian life. Physicians should routinely roentgenograph patients coming in for general physical examinations; hospitals should roentgenograph every patient seeking admittance; labor unions should roentgenograph their membership; medical departments in industry, especially war industries, should roentgenograph the chest of applicants for jobs. In fact, every person, young or old, should be roentgenographed. How often roentgenographing of such groups should be repeated depends upon many circumstances. If funds or facilities are limited, one should begin with sex, age, racial and economic groups in which the disease prevails.

Tuberculosis is an obstacle on the road to victory. The White Plague is still the disease which leads all others as a cause of death in the most productive period of life, the ages between 15 and 45. It is one of the great wasters of productive manpower.

For many years, the State Medical Society of Wisconsin, through its Committee on Tuberculosis and Chest Diseases, and in cooperation with the Wisconsin State Board of Health, has cooperated with the Wisconsin Anti-Tuberculosis Association in the early diagnosis and educational campaign during the spring months. Each year the Wisconsin Anti-Tuberculosis Association has prepared something of interest, help and educational value on tuberculosis for Wisconsin physicians. This year a booklet in graphic form entitled "Tuberculosis Summed Up" will be mailed to you. It contains: (1) Recent facts on tuberculosis, (2) Where deaths occurred, (3) Cases reported, (4) Isolation of the tuberculous, and other information to bring you up to date on the situation in Wisconsin. It also lists the principal needs in the campaign to eradicate this disease.

Be on the lookout for your copy. We know you will like it.

F. E. BUTLER, M. D.
1880–1943

DR. FRANCIS E. BUTLER, a son of Wisconsin, was born August 12, 1880, at Random Lake, Sheboygan County. He died March 12, 1943, at Menomonie, Wisconsin. The son of Richard D. and Mary Walsh Butler, Dr. Butler received his early education at Random Lake and pursued further studies at St. John's Military Academy at Delafield, Wisconsin. He was graduated from that institution in 1895. He entered the Milwaukee Medical College, later to be combined with the Marquette University School of Medicine, from which he was graduated in 1903 as a Doctor of Medicine. In that year he moved to Menomonie, where he was engaged in the practice of medicine and surgery until his death, and where he founded the Menomonie Clinic.

Dr. Butler was married in June, 1908, to Lydia Ostertag, of Oshkosh, by whom he is survived, as well as by his daughter, Mrs. Frances Averill, San Antonio, Texas; a son, Midshipman John R. Butler, of Annapolis, Maryland; and a granddaughter, Eleanore Averill. Also surviving Dr. Butler is a twin brother, E. F. Butler, of Omaha, Nebraska, and his four sisters, Mrs. H. B. Fuhrman, Mrs. J. M. Kelley and Mrs. C. P. Host, Milwaukee, and Mrs. P. H. Kalb, Buffalo, New York.

Dr. Butler had been a member of the Eau Claire–Dunn–Pepin County Medical Society, the State Medical Society and the American Medical Association since 1906. In 1927 he became a fellow of the American College of Surgeons. During his medical career, Dr. Butler served his various professional affiliations in numerous ways and at his death was president of the State Medical Society of Wisconsin. In addition, Dr. Butler was a member of the Menomonie Chamber of Commerce, the Menomonie Rotary Club, the Menomonie City Council and the Knights of Columbus.

Thus are chronicled the major events in the life of Dr. Francis E. Butler, president of the State Medical Society of Wisconsin. But in that chronicle there is little to portray the life of Dr. Butler as a devoted husband and father, as a truly fine physician and surgeon, and as a loyal and trusted friend and counselor of all. "There passes from our midst a real gentleman," said a Menomonie friend, "a gentleman who ever held dear to him the needs and the friendship of the people in his community without regard to their stations in life or their successes as measured in worldly possessions. He was indeed a friend to all."

The State Medical Society of Wisconsin can do no more than record here in the printed pages of its *Journal* the deep respect and the affectionate regard in which Dr. Butler was held by all its members. He served the cause of public health long and faithfully, ever without regard to personal sacrifice or self aggrandizement. He was always ready with a word of encouragement, a kindly comment and his friendly advice. Quick to smile, he had a rare facility for carrying his opinions and thoughts in such a manner as never to give offense or endanger the personal friendship he enjoyed with all who knew him.

The professon has suffered an irreparable loss which is keenly and deeply felt.

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« « « EDITORIAL » » »

Home Canning

DURING the coming summer months countless thousands of American housewives will be busily engaged in the canning of home-grown and store-purchased vegetables and fruits. For many, this will be a new and unfamiliar undertaking. The problems of home-canning are not immediately recognized by the average person accustomed to the use of commercially canned foods.

Realizing the problems involved and anticipating the numerous inquiries likely to be received by the medical profession, the State Medical Society has solicited the cooperation of the Home Economics Department of the University of Wisconsin in the preparation of an exhaustive article on the subject. This will appear in the form of an insert section in the May issue of *The Wisconsin Medical Journal.*

In the interests of public health, it is hoped that physicians will thoroughly familiarize themselves with the contents of this article and will advise those whom they know to be contemplating home canning in regard to the proper procedures to be considered and the dangers involved in the processing and canning of foods as pointed out in the article.

Reprints will be available, and members are urged to request as many as they may need for distribution to patients.

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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The Recruitment of Nurses

"MEDICAL care must be rationed, and we must *eliminate the luxury nursing service* to which Americans have been accustomed." This is a statement which was made recently by Dr. George Baehr, of the United States Public Health Service and chief of the medical division of the Office of Civilian Defense.

The current national campaign for the recruitment of nurses is a challenge in the line of duty to the Woman's Auxiliary to the State Medical Society of Wisconsin—a challenge that can and must be met if we are to supply nurses for our men in active service, nurses for our own hospitals and intelligent nursing care in our homes.

The nursing population of the United States is about 100,000, with a vacancy of 6,000 nurses who are in the armed services today. The Wisconsin nursing population is about 4,000, and sixty-six trained and qualified nurses are needed from our state alone each month. We are not meeting this quota as the call for nurses—and yet more nurses—comes with increasing urgency from our doctors who are serving with our armed forces, from the hospitals throughout the country which are already receiving casualties returned from the war front, from our husbands, sons and brothers who must be given every chance of full recovery and health if we are to justify the sacrifices they are making.

With the depletion of trained personnel from our hospitals and doctors' offices, there is immediate need for nurses' aides in our institutions to form an auxiliary staff for the maintenance of adequate care. The skeleton staff imposed on our hospitals by wartime needs must be augmented by a trained lay staff—by women who are willing to budget their time and resources to include several hours each week in this urgent cause. Fifty thousand women throughout the country have already answered this call by taking training in nurses' aide courses and by serving in the many capacities for which this training qualifies them. But more are needed—50,000 more are needed.

Retired or inactive nurses must return to their profession in this emergency to serve full-time or part-time schedules in our institutions. Many of these women have turned to other activities during the years and have not kept up their professional affiliations, but they form a national resource of vital need today.

The home nursing course is providing skill and knowledge to many women who realize the need for caring for minor illnesses and many chronic afflictions in the home instead of adding to the burden now being carried by our overpopulated and understaffed hospitals.

The need is now! Our response to the annual Red Cross call, which is now in prog-

ress, is mechanical. Our response to this call for nurses is personal and imperative. Can we, as members of the Woman's Auxiliary, with our knowledge and awareness of medical needs and services, do less than implement this program? Can we do less than assure the finest men of our country, who have been drawn into this world conflict and who are proving such valiant ambassadors of the purpose and integrity of our American principles, that we are advancing the health and care of our own abroad and at home by our diligence and determination?

RED CROSS NURSE RECRUITING PUBLICITY COMMITTEE

Mrs. W. E. Sullivan, Madison, *Chairman*
Mrs. J. S. Supernaw, Madison

County Auxiliary Proceedings

Dane

The Woman's Auxiliary to the Dane County Medical Society met on March 8 at the home of Mrs. B. I. Brindley, Tumalo Trail, Madison. Mrs. N. A. Hill was chairman of hostesses, and she was assisted by Mrs. R. E. Campbell, Mrs. I. G. Ellis and Mrs. N. G. Thomas. Mrs. W. E. Sullivan gave a book review.

Dodge

Mrs. R. E. Schoen, Beaver Dam, was hostess to the Dodge County Medical Auxiliary on February 25. During the business session, Mrs. E. P. Webb was elected to the office of secretary to fill a vacancy, and Mrs. Schoen, who is president of the group, announced the appointment of the following committee chairmen, all of Beaver Dam:

Hygeia—Mrs. A. M. Rosenheimer
Public Relations—Mrs. A. A. Hoyer
Sunshine—Mrs. R. F. Schoen
Philanthropic—Mrs. E. P. Webb
Social—Mrs. W. H. Costello
Publicity—Mrs. A. W. Hammond

Because many of the members of this auxiliary are devoting a large part of their time to Red Cross activities, it was decided that hereafter meetings will be held quarterly instead of monthly in order to permit all to concentrate upon the war effort.

After the business session, a social hour was enjoyed. Refreshments were served by Mrs. Schoen.

Fond du Lac

Twenty-one members of the Woman's Auxiliary to the Fond du Lac County Medical Society met at the home of Mrs. H. E. Twohig, Fond du Lac, for dinner on February 25. Assisting hostesses were Mmes. J. E. Twohig, E. H. Pawsat, L. J. Simon and H. A. Devine.

During the business meeting, Mrs. T. A. Hardgrove was appointed to take charge of donations for equipment for Truax Field, Madison. Each member agreed to donate a new deck of playing cards to the camp.

Attorney A. D. Sutherland of Fond du Lac was guest speaker at this meeting. He discussed "Civilian Defense."

Piano numbers were presented by Mary and Ann Twohig and Betty and Adolph Hutter.

Milwaukee

Brigadier General Eugen C. Reinartz, commandant of the school of aviation medicine at Randolph Field, Texas, was guest speaker when members of the Woman's Auxiliary to the Medical Society of Milwaukee County met for luncheon at the Hotel Schroeder on March 12. After being introduced by Dr. Eben J. Carey, dean of the Marquette University School of Medicine and president of the Medical Society of Milwaukee County, Brigadier General Reinartz gave a most interesting talk on the qualifications and duties of a flight surgeon. He has to his credit the longest continuous service as a medical aviation officer in the United States Army.

Past-presidents of the auxiliary were also honored at this luncheon, and they were seated at the speakers' table. Eighty members were present.

Dr. L. J. Van Hecke, a member of the county medical society and commander of the twelfth district of the Women's Field Army, outlined the April campaign for the control of cancer.

Mrs. T. L. Squier, one of the Milwaukee members who plays a vital part in the Girl Scout movement, made a plea for adult leaders of the Girl Scouts. She stated that having Girl Scouts in the auxiliary ranks meant training from childhood in the real meaning of Americanism and the preserving of health.

All members had previously been asked to contribute a book to the Victory Book Campaign, and it was announced that the call was generously answered. The Milwaukee County Auxiliary has donated $200 to the Red Cross.

Plans are being made by the social committees of the auxiliary and the county medical society for a dinner dance to be held on May 15.

Racine

Sixteen members of the Racine County Medical Auxiliary met on March 8 at the home of Mrs. E. J. Schneller, Racine. The greater part of the day was spent in the recreation room on hospital sewing, and in the afternoon a short meeting was conducted.

Members made plans to contribute money for subscriptions to a number of magazines for the men at

Truax Field, and they were urged to search their homes for suitable books and other items needed at the camp.

Rock

Control of cancer was the main subject for discussion at the monthly meeting of the Woman's Auxiliary to the Rock County Medical Society on February 23.

Mrs. Gerald Cunningham of Janesville and Mrs. James Wooten of Beloit, lieutenants of the Women's Field Army for the Control of Cancer, outlined plans for the spring campaign. Dr. W. T. Clark, Janesville, spoke on the cancer clinic at Mercy Hospital.

The sound picture "Enemy X," released by the Women's Field Army and the National Board of Health, illustrated cancer statistics.

Winnebago

Mrs. E. S. Schmidt, state president, was a guest at the monthly meeting of the Winnebago County Medical Auxiliary at the Athearn Hotel on March 4. Sixteen members were present.

At the business meeting which followed dinner, action was taken to pay the dues of members who have left the county auxiliary to be with their husbands who are in service.

Mrs. Schmidt gave a splendid talk on Auxiliary work for the year. She outlined a project for the duration of the war, and asked each member to keep an account of hours spent in war work. She also read a paper on "Modern Advances and New Discoveries in Medicine."

Society Proceedings

Brown—Kewaunee—Door

At a dinner and business meeting of the Brown–Kewaunee–Door County Medical Society held at the Beaumont Hotel, Green Bay, on March 4, Dr. William C. Keettel, Jr., of the Bureau of Maternal and Child Health, the State Board of Health, spoke on "Resuscitation of the Newborn Infant." In addition to discussing the more common methods of resuscitation, he presented material concerning the obstetric aspect of prematurity and the obstetrician's responsibility for the care of the premature infant during the first day of life. He also presented a two-reel film on the treatment of asphyxia.

Clark

When the Clark County Medical Society held a dinner meeting at the Woodland Hotel, Owen, on February 25, Dr. Stephen E. Epstein, Marshfield, spoke on "Management of Skin Conditions in General Practice," and Dr. George L. McCormick, Marshfield, discussed "Acute Infections of the Upper Respiratory Tract."

Dane

The regular monthly meeting of the Dane County Medical Society was held at the Madison Club, Madison, on Tuesday, March 9, at 8:00 p. m. About fifty members and guests were present.

Mr. Vern Zeller, chairman of the Dane County Rationing Board, discussed some of the problems that are arising in the rationing of processed foods. He explained also how doctors can help in completing special blanks when additional fuel oil or gasoline is needed.

Professor Miles L. Hanley of the University of Wisconsin Department of English spoke on "Human Vocal Cords" and illustrated his talk by presenting some interesting and instructive movies. Special slow-motion pictures by the Bell Laboratories showed the actions of cords at low and high pitch, when the subject had swallowed helium, when the mouth passage was blocked, and under various other conditions. A demonstration of the Ford Faryngoscope showed the vocal cords in full activity.

Dodge

The Dodge County Medical Society met at the Hotel Rogers, Beaver Dam, on February 25. "Fracture Problems of the General Practitioner" was discussed by Dr. Henry L. Greene of Madison.

Fond du Lac

The Fond du Lac County Medical Society at its meeting at the Retlaw Hotel, Fond du Lac, February 25, was addressed by Dr. Theodore L. Squier, Milwaukee. The subject of his talk was "Diagnosis and Treatment of Allergies." Twenty-nine members were in attendance.

Milwaukee

On Friday, March 12, the Medical Society of Milwaukee County held its regular meeting at the Athletic Club.

Two talks were presented. Brigadier General Eugen G. Reinartz, Commandant of the Army School of Aviation Medicine, Randolph Field, Texas, spoke on "Aviation and the Doctor." Dr. Edgar M. End of the Marquette University School of Medicine, researcher in the use of helium by deep sea divers and by aviators to prevent collapse where oxygen is scarce, discussed "Atmospheric Pressure in Aviation Medicine."

Outagamie

The March meeting of the Outagamie County Medical Society was held at the Conway Hotel on March 18. Guest speaker was Dr. Paul H. Holinger, Chicago, head of the Department of Bronchoscopy at St. Luke's Hospital. Dr. Holinger spoke on "Bron-

choscopy in Diseases of the Respiratory Tract" and illustrated his talk by lantern slides and colored motion pictures.

Portage

At a recent meeting of the Portage County Medical Society, the following officers were elected:

President—Dr. George W. Reis, Junction City
Vice-president — Dr. Frank C. Iber, Stevens Point
Secretary—Dr. Henry A. Anderson, Stevens Point

Pierce—St. Croix

A 6:30 meeting was held at the Baldwin Clinic, Baldwin, by the Pierce–St. Croix County Medical Society, February 18. Dr. Charles A. Dawson, River Falls, discussed peptic ulcer.

The organization plans to have most of its programs this year put on by its own members, a practice which they have found to be stimulating and very satisfactory.

Walworth

At a meeting of the Walworth County Medical Society on January 6 at the Walworth County Hospital, Elkhorn, the following officers were elected:

President—Dr. Stilwell G. Meany, East Troy
Vice-president—Dr. Dean H. Jeffers, Lake Geneva
Secretary–Treasurer—Dr. Clifford Y. Wiswell, Williams Bay

Washington—Ozaukee

The Washington–Ozaukee County Medical Society selected its 1943 officers at a recent meeting. The following physicians were chosen:

President—Dr. Raymond S. Fisher, Allenton
Vice-president — Dr. Charles A. Balkwill, Grafton
Secretary–Treasurer—Dr. Kenneth F. Prefontaine, Slinger
Delegate—Dr. Arnold H. Barr, Port Washington
Alternate-delegate—Dr. J. Gregory Hoffman, Hartford

Waukesha

At the annual dinner meeting of the Waukesha County Medical Society, March 3, the principal speaker was Dr. Marcos Fernan-Nunez, Professor of Pathology at the Marquette University School of Medicine. His topic was "War Problems in Tropical Medicine" and was illustrated with motion pictures. The general discussion was led by Dr. Gwilym Davies, Waukesha, formerly a medical missionary in Africa, and by Dr. Leander J. Van Hecke, Milwaukee, pathologist to the Waukesha Memorial Hospital.

Winnebago

The dinner meeting of the Winnebago County Medical Society held Thursday evening, March 4, at the Athearn Hotel, Oshkosh, was attended by thirty members. A report on the War Sessions program for the medical profession held recently at Milwaukee was presented by Dr. Stephen E. Gavin, Fond du Lac.

Dr. Ray F. Wagner, Oshkosh, gave an interesting and practical talk on "Gas Warfare and Civilian Defense" in which he discussed the recognition of gases and the importance of treatment. Accordingly, the organization is making plans for a course to be given to cover the practical aspects of gas warfare in civilian defense. Better protection for the community will be stressed.

News Items and Personals

The University of Toronto Charles Mickle fellowship for 1942 has been awarded to *Dr. Arthur L. Tatum*, University of Wisconsin Medical School professor of pharmacology, "the member of the medical profession who has done most during the preceding ten years to advance sound knowledge of a practical kind in medical art or science." Dr. Tatum won this recognition specifically for outstanding work in the study of cocaine poisoning and its treatment, morphine addiction, the use of picrotoxin as an antidote to barbiturate poisoning, and the introduction of mapharsen for the treatment of syphilis.

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Mrs. G. E. Stoddart of Beaver Dam, regional deputy commander and state commander of the Wisconsin division of the Women's Field Army of the American Society for the Control of Cancer, was awarded the Distinguished Service Pin of the association at its three day annual meeting held early in March in New York City. The award was made by Mrs. Marjorie B. Illig, national commander of the Field Army. The decoration was given for outstanding service during the previous year in the cause of cancer control. The first presentation was made in 1937, and since that time, a Wisconsin woman has twice received the award, Mrs. F. H. Clauson of Horicon receiving it in 1939. Mrs. Clauson was responsible for establishing the Bulletin of the Women's Field Army of Wisconsin, and the award was given to Mrs. Stoddart for outstanding leadership in organization.

There is only one award made each year, and the entire country is considered before the award is given.

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Dr. Marshall W. Meyer, Ashland, former director of sanitary district No. 9 in that city, has been named director of District No. 6. He succeeds *Dr.*

Allen A. Filek, now director of the division of tuberculosis and local health services, Madison.

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The Woman's Christian Temperance Union of Janesville had as its guest speaker on February 19 *Dr. Margaret Hatfield*, Janesville, medical director of the Rock County Sanitary Unit. Dr. Hatfield illustrated her address with moving pictures.

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On Thursday afternoon, March 4, Dr. Elizabeth Kane, Madison, of the maternal and child health division of the Wisconsin State Board of Health, gave a lecture in the library of St. Patrick's school, Appleton. Dr. Kane's series of lectures, presented every Thursday afternoon and attended by teachers, clergymen, social service workers, welfare heads, and other interested persons, will be concluded in April.

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At a dinner meeting of the Milwaukee Neuro-Psychiatric Society at the University Club, Milwaukee, on Thursday, March 25, Dr. Josef A. Kindwall, Hartford, Connecticut, spoke on "Conditioned Reflex Treatment (Voegtlin) of Chronic Alcoholism as Observed in Seattle Recently."

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The regular meeting of the Milwaukee Oto-Ophthalmic Society was held at the University Club, Milwaukee, on Tuesday, March 9. The following scientific program was presented:

1. Lateral Sinus Thrombosis—*Dr. Edward A. Waldeck*, Milwaukee
2. Epidemic Keratoconjunctivitis—*Dr. Raymond C. Warner*, Milwaukee

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At the regular meeting of the Wisconsin General Hospital Staff on Tuesday, March 16, *Dr. John E. Gonce, Jr.*, Professor of Pediatrics at the University of Wisconsin Medical School, discussed "Some Aspects of Urinary Infection in Infancy and Childhood."

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In cooperation with the Department of Post-Graduate Medical Education of the University of Michigan, the Committee on Industrial Health of the Michigan State Medical Society sponsored a one day Post Graduate Industrial Medical and Surgical Conference on April 8 in Detroit. The morning and afternoon discussions were based on medical problems relative to war industries. Attention was focused upon industrial hygiene, specific types of injury, disease, illness, disability, and medicolegal phases of industrial employment. Guest speaker at the evening banquet was the Honorable Harry F. Kelly, Governor of the State of Michigan.

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The 1943 meeting of the American College of Chest Physicians has been cancelled by its Board of Regents in accordance with the recently adopted policy of the American Medical Association to limit medical meetings, as far as possible, to those carrying out a definite program of subjects pertaining to the particular needs and services of the medical profession during a period of war emergency.

It was recommended that, wherever feasible, state and district chapters of the College should arrange to meet jointly with their state and district medical societies and assist in preparing scientific programs concerning the specialty of diseases of the chest.

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On February 24 at Racine, Fred Neukom, 63, Winona, Minnesota, was bound over to municipal court for trial on one count of illegal practice of medicine without a state license and was arrested on a second and similar count. Preliminary hearing was on the charge that he treated the late Mrs. Libbie Lorence, Racine, from October 1 to December 22, 1942, the date of her death. One of the witnesses produced in behalf of the state was D. W. Hutton, investigator for the State Board of Medical Examiners.

BIRTHS

A daughter, Jacqueline Mary, to Lieutenant and Mrs. George J. Worm, Milwaukee, on February 23.

MARRIAGES

Dr. John G. Russo, Madison, and Miss Pia Camponeschi, Kenosha, on March 6 at Kenosha.

DEATHS

Dr. Thomas J. Oliver, 68, prominent civic leader and practicing physician in Green Bay for thirty-eight years, died Saturday, March 13. He was a former president of the Brown-Kewaunee Medical Society and public health officer of Green Bay. Following graduation from the Wisconsin College of Physicians and Surgeons, Milwaukee, in 1898, he practiced at Eden until 1905, at which time he began his practice in Green Bay. Dr. Oliver was author of "The History of Medicine in Brown County," published by the State Medical Society of Wisconsin.

Survivors are his widow, two daughters, and a son, now a doctor in the Navy.

Dr. Carl von Neupert, 72, oldest physician in Stevens Point in length of active practice, died Monday, March 15.

He was born in Forchheim, Bavaria, and came to America at the age of nine with his parents, the late Dr. and Mrs. Carl von Neupert, Sr. He received his education at the University of Minnesota Medical School and located in Stevens Point in 1889. In 1891 he went to Kentucky to complete his medical training and was graduated from the Louisville Medical College, Louisville, Kentucky, in 1892. He returned to Stevens Point in 1892.

He was awarded a fellowship in the American College of Surgeons in 1913. One of the oldest members of the State Medical Society of Wisconsin, he was made a life member by the Council in June, 1940. He was a member also of the Portage County

Medical Society and the American Medical Association. At the time of his death, he was Portage County physician.

He is survived by his widow, a daughter, and a son.

Dr. James A. Hinrichsen, 75, Larsen, a practicing physician in Winnebago County for more than forty-five years, died Thursday, March 4, following an illness of a year.

He was born in Denmark and came to the United States as a young physician. In 1894, he was graduated from the National Homeopathic Medical College, Chicago. He settled first in Chicago. From Chicago he moved to Neenah. For many years, he had lived at Winchester and Larsen.

At the time of his death, he was a member of the Winnebago County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors are his widow and two grandchildren.

Dr. Halfdan Raasoch, 70, for more than forty-three years a prominent physician of Nelsonville, died Friday, February 19, after a short illness following a heart attack. He had been in ill health for the last nine years, but most of this time he had been able to attend to his medical practice.

Dr. Raasoch was born near Oslo, Norway. At the age of nine, he came to the United States with his parents. The family located in Chicago, where Dr. Raasoch received his education. Upon graduation from the Northwest Division High School, he was awarded the Chicago Daily News scholarship to Rush Medical College, from which he was graduated in 1896 with special honors. He established a practice in Nelsonville immediately after completing his interneship in a Chicago hospital.

He was a former president of the Ninth Councilor District and a former member of the Portage County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, three daughters, and a son.

Dr. Edward M. Lawler, 36, a physician in Cudahy and Milwaukee for the last ten years, died suddenly of a heart attack Saturday, February 27.

He was a 1930 graduate of the Marquette University School of Medicine and interned at the Milwaukee County Hospital. At the time of his death, he was vice-chairman of the Medical Business Bureau of the Medical Society of Milwaukee County and held memberships in the State Medical Society of Wisconsin and the American Medical Association.

He is survived by his widow, his parents, four brothers, and three sisters.

Dr. Nels Warner, 63, Eau Claire, died of a heart attack on Friday, February 26. After having practiced as a physician and surgeon at Barron for eighteen years, he had been a member of the Midelfart Clinic staff at Eau Claire during the last twenty years. He was a graduate of Rush Medical College.

At the time of his death, he was a member of the Eau Claire–Dunn–Pepin County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, a son, and a daughter.

Dr. Joseph Dean, 64, prominent Madison physician and surgeon, died March 6 at his home in Maple Bluff. He suffered a heart ailment and had been in ill health since retiring from practice in 1938.

Dr. Dean was born in Madison in 1878. From 1897 to 1898, he was a student at the University of Wisconsin. In 1902, he was graduated from the University of Illinois College of Medicine, Chicago. After an interneship of two years at Cook County Hospital, he opened an office in Seattle, Washington. He remained in Seattle for only six months and then returned to Madison.

He began the practice of medicine in Madison on August 1, 1904. From 1905 to 1921, he was associated with the Madison General Hospital and was one of the chief sponsors in the building of St. Mary's Hospital. A permanent testimonial to his character is given by a bronze plaque bearing his name and erected over the entryway of St. Mary's Hospital. In 1929, he and his brother, Dr. James Dean, founded the clinic which bears their name. Two sons were associated with him in his medical practice in Madison, Dr. Joseph C. Dean and Dr. Frank K. Dean.

At the time of his retirement in 1938, Dr. Dean was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Under appointment by Governor John J. Blaine, he served as a member of the State Board of Health from 1925 to 1931 and was later reappointed by Governor Schmedemen for the term ending in 1939.

He is survived by his widow, two sons, a daughter, six brothers, and two sisters.

Dr. Emil Gunther, 75, Sheboygan, died Monday, March 8, at St. Nicholas Hospital in that city. Following forty-nine years of activity in the medical profession, he had retired in 1941 on his seventy-third birthday. Specializing in obstetrics, he had brought more than 5,000 children into the world during his career of nearly half a century.

He was born in Sheboygan and, except for the years spent at Rush Medical College, Chicago, had lived there all his life. Upon graduation from college, he started practicing medicine with his brother, the late Dr. William Gunther. During the later years of his practice, he was associated with the Sheboygan Clinic.

He was a past member of the Sheboygan County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

His widow, two sons, and a daughter survive him.

Dr. Harry A. Vedder, 63, Marshfield, widely known surgeon of central Wisconsin, died at his

home Friday, March 12. He had been in poor health for four years and had not practiced for the last two years.

He first came to Marshfield with his parents in 1885. He was graduated from the Northwestern University Medical School, Chicago, in 1905. He practiced in Edgar until 1916, when he returned to Marshfield and entered into a partnership with his brother. In 1920, the brothers joined the Marshfield Clinic. In 1937, he served as chief of staff of St. Joseph's Hospital. He was also surgeon for the Chicago, North Western and Omaha Railway Company from about 1925 to the time of his death.

He was a member of the Wood County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors are his widow, a son, and a daughter.

Dr. C. F. Rosenberg, 33, Milwaukee, died Saturday, February 27, at the Columbia Hospital. He formerly was a member of the staff of Normandale Sanitarium, Madison. He was a graduate of the University of Wisconsin Medical School and served his interneship at the Madison General Hospital.

He is survived by his widow, his parents, a brother, and a sister.

Dr. Herman F. Fleischer, 81, who practiced medicine at Clintonville for about thirty-five years until his retirement fifteen years ago, died March 5 at his home. He had been living in Milwaukee since his retirement.

He received his medical education at the Marquette University School of Medicine and at Rush Medical College, Chicago.

Surviving him are his widow, a son, and four daughters.

Dr. Anton D. Beire, 62, Milwaukee, died Tuesday, March 2, at the Milwaukee General Hospital.

He was graduated from the Wisconsin College of Physicians and Surgeons, Milwaukee, in 1905 and practiced medicine in Cadott until he went to Milwaukee.

His widow, one son, and two daughters survive him.

Coming Events

Wisconsin General Hospital Staff Meetings for 1943

The Wisconsin General Hospital staff meetings, held in the Auditorium of the Service Memorial Institute, are restricted in attendance to third and fourth year medical students, internes, residents, hospital and medical school faculty, and interested outside physicians.

April 20—Dr. K. L. Puestow: Sigmoidoscopic and Radiologic Correlation in Diagnosis and Treatment of Colonic Disorders

May 4—Dr. E. A. Pohle: Indications and Contraindications for Roentgen Therapy

May 18—Dr. L. W. Paul: Fundamentals of Gastro-Intestinal X-Ray Diagnosis

War Conference

The medical, surgical, and industrial hygiene experts who are so ably safeguarding the well-being of more than 20,000,000 industrial workers have agreed to pool their knowledge and exchange their experiences regarding the many new and complex problems of today's wartime production. For this purpose, their organizations, the American Association of Industrial Physicians and Surgeons, the American Industrial Hygiene Association, and the National Conference of Governmental Hygienists, are combining their annual meetings in a four-day War Conference at Rochester, New York, May 24–27, 1943.

Among the problems to be discussed from a practical standpoint are the following: older-age employees, with their various associated problems; proper placement and employability considerations of the 4F rejectees; rehabilitation and proper employment of those already discharged from the military services because of disabling conditions; toxic and other hazards from new substances, new processes, and the use of substitute materials; absenteeism; fatigue; nutrition; effects of long hours; double shifts; two-job workers; overtime; increased industrial accident rates; advances in the treatment of illnesses and injuries; and many others.

This joint meeting will be a report on the state of the nation by men outstanding in their knowledge of matters of industrial health. Dr. William A. Sawyer, medical director of Eastman Kodak, is general chairman; Dr. James H. Sterner and Lieutenant Commander J. J. Bloomfield are arranging the programs for the industrial hygienists.

Physicians and surgeons, hygienists, engineers, nurses, executives, and any others who are interested in the problems of industrial health and their solution are invited to attend as many of the sessions as possible. No registration fee is required.

International College of Surgeons

The Fourth International Assembly of the International College of Surgeons will be held on June 14, 15, and 16 at the Waldorf Astoria Hotel in New York City, it is announced by Dr. Fred H. Albee, International President. The program will be devoted to war surgery and rehabilitation.

Delegations made up of prominent surgeons from the United Nations, in addition to those from other countries, are expected to attend. The United Nations representatives will give outstanding examples of the progress being made in war surgery and rehabilitation under battle conditions by their respective countries.

Eminent surgeons in government military and civilian executive offices have voiced approval of the Assembly, which also has the cooperation of the Latin American Chapters of the International College of Surgeons.

Time: Friday, May 7, 1943
Name: Annual Marquette Medical Alumni Spring Clinic
Place: Marquette University School of Medicine

A. M.
8:30 Registration
9:10 Welcome
9:20 Breast Tumors and Metastases Seen—Dr. Francis Paletta (Alumni Award)
9:40 Hyperplasia of The Adrenals—Dr. Theodore Bratrud (Alumni Award)
10:00 Head Injuries—Dr. Harold Cook
10:20 Recess
10:30 A Review of Infra Red Photography in Medicine—Mr. Leo Massapust
10:50 Anatomical Subjects—Dr. Walter Zeit
11:10 Lesions of The Oesophagus—Dr. Joseph M. King
11:30 Forum on History of Medicine 1775–1943

P. M.
12:15 Luncheon—Ambassador Hotel
2:00 Stasis Ulcers—Dr. R. M. Kurten
2:20 Injuries to The Bones of The Hand and Wrist—Dr. J. R. Regan
2:40 Kidney Complications of Sulfonamides—Dr. F. D. Murphy
3:00 Vaginal Outlet in Obstetrics—Dr. Wm. Wagner
3:20 Recess
3:30 Transfusion Reactions—The R. H. Factor—Dr. L. J. Van Hecke
3:50 Left Subphrenic Abscess—Dr. G. S. Flaherty

Wisconsin Anti-Tuberculosis Association

Tuberculosis rejectees and the effect of war conditions on tuberculosis will be themes of the thirty-fifth annual meeting of the Wisconsin Anti-Tuberculosis Association at the Pfister Hotel, Milwaukee, May 7 and 8.

Principal speakers on the war theme will be Dr. Robert Hughes Parry, medical officer of health, Bristol, England, who will address guests at the annual dinner at 6:30 p. m., May 7. Dr. Parry is now in the United States relating experiences of his home city, one of the principal targets of air attack during the Nazi "blitz."

Dr. Eben J. Carey, dean of the Marquette University School of Medicine, will be toastmaster.

Tuberculosis rejectees will be discussed at a meeting on the morning of May 8. Speakers will include Dr. Carl A. Neupert, state health officer, Miss Dorothy Paull of the WATA social service department, and probably Captain William H. Stearns, assistant, tuberculosis section, medical corps, office of the surgeon-general of the War Department.

Sectional luncheons of four affiliate groups, the Sanatorium Trustees' Association, the Sanatorium Superintendents' Association, the Wisconsin Trudeau Society, and the Come-Back club, will be held May 8 at 12:15 p. m.

A business meeting of the WATA, followed by a session of the board of directors, will be held May 7 at 3 p. m.

Correspondence

Illinois State Medical Society
Chicago, Illinois, March 19, 1943

Mr. C. H. Crownhart, Secretary
State Medical Society of Wisconsin
Madison, Wisconsin

Dear Mr. Crownhart:

Your organization will undoubtedly receive a formal invitation to our Annual Meeting, May 18, 19, 20, 1943, but we would like to write you personally asking that you give the meeting whatever boost you can.

Inasmuch as our national medical meetings are to be eliminated, we are endeavoring to make this as beneficial to the profession as a whole as is possible. The scientific papers prepared so far are of a high order, and we will meet the appeal of different groups by having general sessions and special sections. We are stepping up our scientific exhibition angle, and we believe the commercial exhibits will likewise increase in number and appeal.

To keep in touch with recent trends, we are setting aside a special Army Day and a special Navy Day. Military medicine will be featured on these days and will do much toward keeping us abreast of these developments.

Conventions have always proven a splendid place to renew old friendships, and as an adjunct thereto, golf will be on the cards both for individual and tournament play. As usual of course, the ladies will be provided for through the auxiliary organizations.

Convention headquarters will be at the Palmer House, which is splendidly equipped for our purposes with its many exhibition rooms, conference rooms and parlors.

Members in good standing of your organization, being our own good neighbor, will of course be free of any obligation as far as registration charges are concerned. We will be happy to welcome them and promise an outstanding effort in their behalf.

Very sincerely yours,
(Signed) H. K. Scatliff, M. D.
Chairman, Publicity Committee,
Annual Meeting, Illinois State Medical Society

The Press

The Soul of Medicine

"IT HAS become axiomatic for those who criticize medical men opposed to a fundamental change in the American medical system to assume that the doctors have a particular ax to grind. As a matter of fact, the doctors have only one concern: the preservation of present high medical standards. As far as financial reward goes, the average doctor could make more money under practically any other system than the present one, which far too often pays him off in nothing more tangible than the satisfaction gained from a job well done; of seeing a sick person made healthy by his skill and experience.

"The doctors who today are carrying forward the best traditions of centuries of medical progress simply do not feel bound to kneel before the fancies of social reformers whose only idea of progress is the steady growth of bureaucracy.

"For example, they are opposed to compulsory health insurance which is merely a polite word for socialism. Experience in Europe shows that people 'protected' by such insurance do not get the medical care now provided by the American system under which the most skilled specialists and surgeons are available to all, regardless of income or economic status.

"The following comment of Doctor Edward H. Cary, chairman of the National Physicians Committee on compulsory insurance, expressed the viewpoint of the average doctor—a viewpoint typical of the American medical system in its approach to the whole health problem: 'Compulsory insurance introduces the principles of differing qualities of medical care. It would make the doctors mercenary money grabbers and destroy their incentive to greatest efficiency. It would destroy the soul of medicine. It would undoubtedly lower the quality of medical care—and those who would suffer most would be not the doctors, but the general public—those who are afflicted with disease.' "—*An Editorial: The Merrill Herald, February 20, 1943.*

News of the Neighbors

The Changing Years

"The practice of our profession, for many years the target of self-centered individuals, is no longer as secure as we had thought it to be. Many restrictions that for some months appeared to be only chimerical are now in the immediate offing. The medical profession, stripped of so many of its members, has a gigantic task ahead of it. With our limited numbers we must carry on in the guarding of the health of our Army and our civilian population, even though it means more work and extra hours; this is expected of us, and never has the medical profession failed in meeting such expectations.

"And, while we are carrying on these additional duties, we must be on the lookout for additional attacks from within. We say 'within' for the reason that the profession already harbors many renegades, doctors who are wholly self-centered, have no regard for the professional interests and have openly allied themselves with those who would bring about the regimentation of the greatest of all the professions.

"One of our best weapons against these attacks is the continual 'hammering home' to our patients and our friends the fact that the medical profession is rendering an invaluable service to the country in time of war, and that it is more than unfair to be compelled to fight these attacks at a time when almost forty thousand of our members are in actual war service.

"Let's wake up to the fact that we have a whale of a big job before us—that of caring for the folk at home and fighting off an insidious enemy!"—From an editorial appearing in the January, 1943, issue of *The Journal of The Indiana State Medical Association.*

Canadian Medical Society and the Government Confer on Sickness Insurance

"The movement for sickness insurance in Canada has progressed to the point of discussions between the government and the Canadian Medical Associa-

tion, according to an article in *The Journal of the American Medical Association* based on reports from Canada.

"The Manitoba Medical Association, according to the article, recently adopted the following resolution:

" 'That we instruct our representative on the executive committee of the Canadian Medical Association we are in favor of the medical profession in Canada cooperating with the government in devising a scheme to provide the benefits of modern medicine for all citizens of Canada whose income is not sufficient to provide it for themselves, and the basis of the scheme should be medicine as at present practiced—patients to have free choice of a regularly qualified and registered medical practitioner.'

"For the last year, the Manitoba Medical Association has been on record as favoring the establishment in Canada of a 'surgical only' medical care plan and a complete coverage plan for families with less than $2400 annual income. These plans have to be approved in principle by the physicians of Greater Winnipeg."—From the February, 1943, issue of the *Ohio State Medical Journal.*

Juggling the Bureaus

". . . The critics who demand new agencies and new laws forget that no matter how they juggle the bureaus they will still be dealing with a limited number of men and men who have the same right of preference about where they will work as the welders and riveters. The proposal to lower license standards for the duration of the war might indeed be the answer in exceptional instances; but the general assumption that a poorly trained physician is better than none at all is open to argument even in war time and the difficulty of revoking special wartime licenses when the war is over must be considered.

"The logical answer to the problem has already been made in many isolated communities throughout the country and is being encouraged and implemented on the basis of careful studies by Procurement and Assignment. That is an effective reorganization of the time and services of the doctors who remain at home.

"That is what physicians of Portland, Oregon, have done, for example, in dealing with the medical problems of the Kaiser plants which in themselves created a monster boom town problem on the Pacific coast. If it could be done there without forced relocation of physicians and sacrificing of licensing standards, it can be done elsewhere. State Committees of Procurement and Assignment are now not merely combing their lists for men who can be spared to fill Army quotas for 1943 but are carefully studying the civilian situation in their states with a view to just such local readjustments and reorganizations."—From the "Medical Economics" section of the February, 1943, issue of *Minnesota Medicine.*

Lay Plans For Medical Service

"Lay organizations and agencies frequently plan and promote various activities having to do with medical matters. This fact may indicate that there are medical needs which the profession has overlooked or has neglected. Frequently, these activities become accomplished facts before the medical profession is consulted.

"Too often in the past physicians have refused to cooperate with lay agencies and have frequently attempted to obstruct their activities. This reaction is a perfectly normal one. However, cooperation and active direction by the medical profession have accomplished much good; from the standpoint of public relations they are most valuable.

"Alert medical leaders should constantly be watching and studying the public trends in relation to medical services. They should have plans to meet these medical needs before they are demanded by the public and before lay agencies have inaugurated them. However, when a lay plan for medical service which has merit is presented, the profession should cooperate and assume the direction of this medical activity. Attempts to obstruct such plans react badly upon the medical profession."—President's Page: Cooperation and Direction, or Obstruction, J. Michigan M. Soc. 42:127 (Feb.) 1943.

Buck Private, M. D.

"Considerable interest is being expressed in the plight of a young Chicago medical man who failed to heed the call of the Procurement and Assignment Service, after he had been 'cleared' by his local committee. It seems that his local board called him in for induction, and he now finds himself a private in the United States Army. Certainly, there has been enough publicity from medical sources to advise all physicians as to what might be expected of them. If a doctor simply ignores all these things, then finds himself a buck private in the Army, he is entitled to no sympathy on the part of anyone."—Editorial Notes, J. Indiana M. A. 36:82 (Feb.) 1943.

Medical Journals Dull Reading?

"Dr. Julian P. Price, Secretary of the South Carolina Medical Association and Editor of the *Journal of the South Carolina Medical Association,* in an address before the Annual Conference of Secretaries and Editors of Constituent State Medical Associations in Chicago last November, took editors of state medical journals to task in a manner which pleased his listeners immensely. Goodnaturedly he chided them for the dullness of their publications. He said:

" 'I have never understood why so many physicians who are charming conversationalists, good impromptu speakers, and adept story-tellers, will discard their individualities entirely when they begin to write for a medical journal. Throwing aside those epigrammatic sentences, those salty phrases, those apt quotations, and those bits of subtle humor which make their informal speech so delightful, they

adopt that stilted and rather ponderous style which is so characteristic of most medical writing. Much of the material which appears in our journals is so similar that the editorials, the comments, and the news reporting could be transplanted from one publication to another with a slight change of local color and no one would be the wiser. Read our journals and you will find much of what is written weighted down with trite headings, stereotyped phrases, involved sentences, and polysyllabic words.' " —From an Editorial, M. Ann. District of Columbia, 12:76 (Feb.) 1943.

Trade News

There Have Been Rumors That Pablum is Off the Market

Pabena, the new Pablum-like precooked oat cereal, does not replace Pablum. Pabena is now being marketed in addition to Pablum.

Pabena offers substantially all of the nutritional qualities of Pablum and all of its advantages of ease of preparation, convenience and economy. The base of Pabena is oatmeal (85 per cent) which gives it a fine flavor and offers variety to the diet.

Would you like some of both for use in your own family? Mead Johnson & Company, Evansville, Indiana, U. S. A.

Salvage Ampule Files

Taking the initiative in a campaign to conserve steel ampule files, Schering Corporation is enlisting the cooperation of physicians and pharmacists throughout the country.

The two tons of steel used each month in the manufacture of the ampule files have been directed to war production, and the existing supply of these files must therefore last for the duration. This should not cause undue concern, however, for many files lying about unused in physicians' cabinets are in excellent condition and can be put to good use in the future.

To be certain that there are sufficient files for the future needs of the medical profession, Schering Corporation is requesting physicians to send in their excess supply of files to pharmacists and dealers in a special envelope being provided currently by the pharmaceutical manufacturer. Files returned to Schering Corporation will be tested and sorted. Those in good condition will be redistributed to physicians as the necessity arises. Files which can no longer cut satisfactorily will be contributed to the national scrap metal salvage drive. Judging from the great weight of steel used for the manufacture of files in the past several years, a not inconsiderable quantity of metal, which is at present idle, should be secured by the government.

One may look upon this campaign as a type of voluntary rationing, for its success depends upon the efforts made by the individual physician to clean out his cabinets, bag, etc., and return the files.

Since ampule files are made of high grade steel and each one can be used for opening forty or fifty ampules, physicians will do well to retain only a few for their immediate requirements and to turn in the remainder.

1943 Schering Handbook Available

The completely revised 1943 Schering Handbook is now available. It contains discussions of most recent therapy of major endocrinologic disorders such as the menopause, dysmenorrhea, etc., and their treatment with hormones. The special applicability of Pranone to mestrual abnormalities, as well as other uses of the corpus luteum hormone, are described in detail. In addition to hormone therapy, the use of newer therapeutic agents, such as a gold compound, Solganal-B Oleosum for rheumatoid arthritis, and Sulamyd for urinary tract infections, will be found in the new Handbook. Listed are prices and packagings of all products including the recently reduced prices of Pranone, the orally effective corpus luteum hormone, and Proluton for injection.

Copies are available from the Medical Research Division, Schering Corporation, Bloomfield, New Jersey.

Parke–Davis Wins Army–Navy "E" for War Production

Detroit, already world-famous as democracy's arsenal of war weapons, achieved prominence in a new field Friday, February 26, when 2,700 employees of Parke, Davis & Company received the Army–Navy "E" pennant for excellence in production of materials for saving lives.

Brigadier General John M. Willis, commanding general at Camp Grant, Illinois, presented the symbolic "E" pennant, which was received by Dr. A. W. Lescohier, president of the company.

Sterling Drug Announces Appointment

Appointment of John M. Hawkins as vice-president of the American Ferment Company, Inc., a subsidiary of Sterling Drug, Inc., has been announced by James Hill, Jr., president of the parent company.

Mr. Hawkins succeeds J. H. Cummings of Buffalo, who founded the business thirty years ago and who is now retiring from active participation in it.

At the same time, Mr. Hill said that the headquarters and physical facilities of the American Ferment Company are in process of being moved from Buffalo. The manufacturing plant will be located in Trenton, N. J., while the executive and sales offices, as of March 1, will be at 170 Varick Street, New York.

New Electron Microscope Announced by General Electric

Electricity that has been "freed from the bondage of wire transmission" is being used by General Electric engineers to study minute specimens invisible under the ordinary light microscope. This electricity, in the form of electrons, is shot from a small electron gun at a fluorescent screen eleven inches away, and similar to that used in a television set. The specimen is inserted between gun and screen, and as the electrons pass through or around it and are magnified, they form an image of the specimen on the screen.

This action takes place in a simplified electron microscope described by Dr. C. H. Bachman in a talk on January 23 at Columbia University, New York, before a joint meeting of the American Physical Society and the American Society for X-Ray and Electron Diffraction.

The instrument, which can be plugged into the regular 110 volt A. C. house circuit, is capable of producing images 10,000 times the size of the subject. Further enlargement of the picture can be made photographically up to 100,000 times the size of the original specimen, or better, if desired.

If a hair 1/100 of an inch across were split lengthwise into 100 slivers, and ninety-nine of these pieces were thrown away and the one remaining piece was split again into 100 similar pieces, each of these filaments only 1/1,000,000 of an inch across would stand out clearly in the G. E. instrument.

The machine is expected to expand the use of electron microscopy in laboratories now engaged in war work and medical research and eventually to find wide usage in high schools and colleges. Due to present priority requirements, the device will be available for use only in essential laboratories and war plants.

The new microscope has an over-all height of fifty-two inches and requires floor space of about two by three feet. The cabinet includes the simple power supply, the mechanical vacuum pump, and an air-cooled, oil diffusion high vacuum pump. A camera is provided for mounting on the front of the instrument for photographing reproduction when this feature is desired. The cabinet is mounted on castors for mobility and weighs 600 pounds. No special facilities for operating the instrument are needed, and the unit includes the microscope proper and all auxiliaries.

Physically, the microscope has been designed for the convenience of the operator. The electron chamber is mounted horizontally, the eye piece at one end being at eye level for an operator seated before the instrument. The electron chamber is supplied with voltage and is evacuated from the end which extends into the cabinet. All controls are at the operator's fingertips. These include accelerating voltage, image intensity, the main vacuum valve, focus control, and the movement of the specimen. In effect, the operator is seated at a desk with a drawer beneath so that materials and notebooks are conveniently at hand.

SOCIETY RECORDS

New Members

A. J. Baer, Milwaukee.
Francis Hauch, Kaukauna.
E. T. Rathert, Chilton.
A. L. Tatum, Madison.

Changes in Address

M. W. Garry, Montreal, to 710 North Plankinton Avenue, Milwaukee.

M. W. Meyer, Ashland, to City Hall Annex, Green Bay.

W. W. Van Zanten, Sheboygan, to Oostburg.

M. V. Overman, Greenwood, to Neillsville.

B. P. Ingersoll, Plainfield, to Adams.

THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

The Medical Clinics of North America. Boston Number. Volume XXVI, Number 5. Symposium on Specific Methods of Treatment. Twenty-one contributors. Cloth. Price, $16 per clinic year. Pp. 306, illustrated. Philadelphia: W. B. Saunders Company, September, 1942.

This Boston number of "The Medical Clinics of North America" is predominantly a symposium on specific methods of treatment. Obviously, this means that it is a particularly practical collection of articles for the clinician, and every article is a good summary of the time-honored as well as the newer methods of therapy in a wide variety of conditions. The material is authoritative and well organized, and the volume is particularly to be recommended as having a wide range of usefulness. M. L. C.

The Medical Clinics of North America. Philadelphia Number. Volume XXVI, Number 6. Symposium on Endocrinology. Seventeen contributors. Cloth. Price, $16 per clinic year. Pp. 342, illustrated. Philadelphia: W. B. Saunders Company, November, 1942.

This volume, compiled by a number of clinicians and a few laboratory workers in Philadelphia, presents much interesting reading with the individual points of view of the authors frankly presented. It is not a consistently planned book, as may be noted

BLOOD FOR THE BRAVE

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in the various concepts of the diagnosis of hypothyroidism and hyperthyroidism and the varied technics for applying thyroid in treatment of hypothyroidism or gynecologic disorders. The general practitioner will find a considerable emphasis in some of the chapters on highly complicated methods of bioassays for hormones. This is almost unavoidable if the subjects are to be treated in any detail and with any semblance of diagnostic accuracy. There is a conspicuous contrast in the case of some discussions of pituitary diagnosis where concrete methods with any validation of the results will be found lacking.

It is rather disturbing to see two contrasts such as a statement by one author that there is no commercial growth hormone available when many clinicians have been using it with success, and in another chapter there is definite recommendation for consistent use of oral anterior pituitary materials to secure growth and development. In this way the volume presents current thought among clinical endocrinologists with a fair cross section.

The book is to be especially commended for an exceptional chapter on the diagnosis and treatment of thyroid disease by Dr. Edward Rose and very helpful discussion of the surgical and radiologic aspects of therapy of thyrotoxicosis. A very helpful treatise on the diagnosis and treatment of amenorrhea is provided by Dr. Israel. The entire volume will be of much interest to those clinicians who would like to know what experienced clinical endocrinologists are thinking and recommending at present. E. L. S.

Sulfanilamide and Related Compounds in General Practice. By Wesley W. Spink, M. D., F. A. C. P., associate professor of medicine, University of Minnesota Medical School. Ed. 2, revised and completely reset. Cloth. Price, $3. Pp. 374. Chicago: The Year Book Publishers, Inc., 1942.

This second edition, like the first, is a practical, useful work of reference for the practitioner. Enlarged considerably and brought up-to-date by the prompt revision of the first edition, a better book is the result. Nearly all of the pertinent data regarding the sulfonamides that are used clinically is now contained in this compact volume.

The information presented is based on the wide experience of the author and an extensive perusal of the literature. In this edition there is amplification of the discussions on principles of sulfonamide therapy and mode of action of the sulfonamides. There are several new and useful tables. One of the most valuable of these, on page sixty-seven, lists the diseases for which sulfonamide compounds are of no value. In this table, among other diseases, there is included influenza, the common cold, tuberculosis, arthritis, rheumatic fever and chorea. There is an extensive bibliography of more than 800 references.

The material is presented with lucidity and concreteness. Although this book may quickly become outmoded because of rapidity of progress in the field, in which event one might presume that a new edition might be forthcoming, still the reviewer highly recommends this work to all clinicians, for a wealth of material, soundly presented, is available. Too, the price is small, justifying expenditure for a book which might soon be replaced by a still newer edition. O. O. M.

Psychosomatic Medicine Monographs. Volume III, Numbers 1 and 2, sponsored by the National Research Council. The Sexual Cycle in Women. The Relation Between Ovarian Function and Psychodynamic Processes. By Therese Benedek, M. D., and Boris B. Rubenstein, M. D., Ph. D., research associate, department of metabolism and endocrinology, Michael Reese Hospital, Chicago; research associate, Institute for Psychoanalysis, Chicago. Paper. Price, $3.50. Pp. 307. Baltimore: Williams & Wilkins Company, 1942.

This monograph by Drs. Therese Benedek and Boris B. Rubenstein will be of considerable interest to the endocrinologist as well as the psychiatrist. The close correlation, long suspected, between the psychologic phases of sexual drives and estrogenic alterations appears to be well established by the careful work of these two investigators. This study prepares the way for a more intelligent trial of such substances as progesterone. To the reviewer it seems unfortunate that no report is included on a trial of this or other similar substances. A. C. W.

Doctors of the Mind. The Story of Psychiatry. By Marie Beynon Ray. Cloth. Price, $3. Pp. 335. Boston: Little, Brown & Company, 1942.

"Doctors of the Mind" is a descriptive history of psychiatry by a free-lance journalist. Her interest in psychiatry developed as the result of interviews with doctors in preparation for a series of feature articles and for her first book "Two Lifetimes in One."

Her history of psychiatry really begins with Mesmer, though we all know there are earlier important events which date the beginning of psychiatry to ancient times. She has ably given a view of the Mesmer period and a sympathetic interpretation of Mesmer who unfortunately too often has been regarded as a charlatan and this period of psychiatry as a period of darkness. The author brings out clearly the relation of Mesmerism to subsequent developments, to the battle which waged around hypnosis, and ultimately to psychoanalysis. The men playing important roles in this phase are each presented, given substance and color, enhancing the usual historic presentation of factual material. These chapters dealing with Mesmer, Liebeault, Bernheim, Charcot, Janet, Dubois, and Dejerine are perhaps the best. It seems a rather unfortunate selection for the title to one of these chapters as it appears in the table of contents to be "The Nasty Little Science," and explanatory "From Animal Magnetism through Hypnotism to Psychoanalysis." It is only in the last page of the chapter that a reason, or rather an excuse, appears for the selection of this phrase as a title.

In her chapter dealing with Freud, she has faithfully produced the basic psychology upon which the

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framework of psychoanalysis has been evolved. It is noteworthy that one readily grasps the development of the Freudian psychology, but the author fails to give substance to Freud himself as she does in the case of Charcot, Liebeault and Bernheim, to mention a few whose personalities she makes one feel. This may be because an adequate biographer for Freud has not yet appeared on the scene.

Mrs. Ray has not neglected the physiologic contributions to the development of psychiatry, and she rightfully refers to Adolph Meyers psychobiology as the "American School of Psychiatry." On the physiologic side, she covers the Wagner–Jauregg contribution to the treatment of paresis, malaria, as well as the discovery of cause of syphilis, development of serologic tests and Ehrlich's 606. From this period she carries the reader into the modern and current era of endocrinology, biochemistry, vitamins, shock treatment, electroencephalography, prefrontal lobotomy (which she erroneously terms lobectomy) and freezing. Names and persons familiar to many appear in connection with these latter advances (if your sense of humor permits you to regard freezing, shocking, and severing ones frontothalamic tracts as advances).

The eagle eye of a medical reviewer of books on a medical subject by and for the layman is peeled for scientific inaccuracies, over enthusiasm and exaggerations. These are found in this book, but the author in this instance shares the responsibility with three members of the medical profession, two of whom receive much attention in the text (Sakel, Burlingame, and Wile). In her conversational manner of writing, it is not always possible to separate her own comments from ideas her historic actors are producing. For instance, this statement appears without italics: ". . . Almost everyone can be hypnotized, the healthy and the strong-minded more readily than the hysterical. Indeed the hysterical are comparatively difficult to hypnotize . . ." Does she ascribe this to Charcot, who differed with Liebeault and Bernheim in the explanation of hypnosis, or is this her misinterpretation (or the reviewers)? And this, "You can remove half a man's brain without depriving him of intelligence, but remove one little ductless gland and you make him an idiot for life." It is hoped that no third and fourth year medical students see this. Paresis is ushered in with, "no slackening of intellectual powers, no, not even a lapse of memory. *No* warning." What if the prospective candidate for "insulin shock" should read this: "When a man or woman goes down, during that deep insulin coma to the gates of death and then comes slowly back . . .," no doubt the expression of Sakel's fears as he watched by the bedside all night waiting for his first patient to come out of his experimentally induced insulin coma. And this must represent a school of endocrinology with which the reviewer is unacquainted: "Everywhere today there are men and women who but for thyroxin would be sitting dull-eyed, weaving

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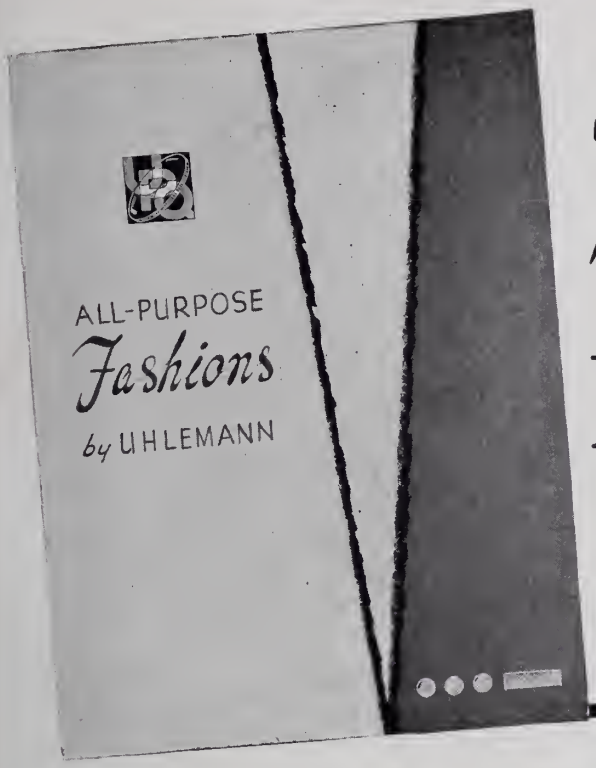

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rugs and baskets, babbling incoherently. A goodly number of people are going around today with nothing between them and idiocy but a shot of thyroxin!"

If these inaccuracies and exaggerations are excused on the basis of her method of presentation, a cultivated dramatization designed to appeal to the lay reader, the work can be said to serve a useful purpose in giving prestige to Psychiatry not as cult or specialty, but a large part of the field of medicine. Surely Menchen regarding the present day therapies of freezing, shocking, and cutting could no longer refer to Psychiatry as "that frail sister of medicine."

A glance thru Mrs. Ray's "Acknowledgements" leaves one with the impression that for her, psychiatry does not exist beyond the Atlantic seaboard, admitting the mention of Franz Alexander, not a native of Chicago, and reference to Bennett in Omaha and Wisconsin's Elvejhem. M. G. M.

Speaking of Man. By Michael F. Guyer, B. S., M. A., Ph. D., L. L. D., professor of zoology, chairman of department of zoology, University of Wisconsin. Cloth. Price $3.50. Pp. 321. New York: Harper and Brothers, 1942.

This book brings to the physician a wealth of scientific information, much of which is of recent origin. The author's own scientific researches in various fields intimately related to common diseases and the many contributions from the department of zoology of which he is chairman go to make up a rich background of scientific medicine which characterizes the volume throughout. He does not stop with man as an individual but recognizes and treats as a biologic phenomenon the social order in which man exists. This wider view with the various problems found only in the human group is the ultimate goal toward which he directs his philosophic opinions.

The first chapter is entitled "Biology and the Happy Life." The degree to which biologic sciences deal with all aspects of mankind will be amazing to many readers. It is shown that human actions, in last analysis, are based fundamentally on biologic processes. The contributions of Spencer, and other pioneers, are quoted. Life is defined as "a continuous adjustment of internal relations to external relations"—a concept which applies to all forms of existing life observable to man. The magnitude of environment is emphasized. The reactions of environment and the organism on each other is a theme that has much practical application in the physician's field of work. Elements of behavior in the lower animal are found in man. The major mechanism, the nervous system and its closely related endocrine system, is shown to be the outcome of a progressive evolution from older and simpler forms of organic life. Favorable and unfavorable influences from the environment are brought to the reader's attention. If some aspects of the environment, particularly those created or influenced by man, were as orderly and as nicely balanced as natural phenomena, human happiness could perhaps be achieved. In short, human existence must be based on biologic processes broadly applied if it is to become "a well ordered, sane, profitable and enjoyable experience." This is the biologist's hope.

A chapter is devoted to "Science and its Critics." The author replies to critics of science in a vigorous defense, with many references to notable achievements and the critical evaluation of data that typifies scientific thinking. He shows in what manner the scientist is free to include religion and perhaps evinces even a greater reverence for the manifestations of life than the theologic dogmatist; for example, the statement that "there may be vaster qualities of mind or personality in nature" does not strike him (the scientist) as "impossible or even improbable." Reference is also made to the frequent charge that the scientist lacks so-called "culture" and is indifferent or blind to aesthetic values or is not interested or capable of appreciating "beauty." This baseless criticism is answered directly but perhaps with even more convincing evidence by the perfectly obvious appreciation and admiration of "beauty" in all its various manifestations revealed by the author himself in his treatment of environment as this is defined by him.

The third chapter is entitled "Man's Place in Nature." This is an interesting and thought-provoking theme in which the opposed views as represented by the vitalistic and the mechanistic schools of thought are discussed. The place that man holds in relation to the universe on the one hand and the minuteness of physical matter on the other hand is very interesting reading.

"The Rise of Intelligent Behavior" comprises the fourth chapter. Here is shown, with supporting evidence in the nature of structural evolution, the gradual progression from the simplest reactions of unicellular organisms responding to external stimuli without the aid of a nervous system through the increasing complexities of behavior which arise as the nervous system becomes more and more complicated in successively higher forms of

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animal life. This tracing of behavior from the simple tropism and reflex through the more elaborate or integrated forms of reflexes to the conditioned reflexes and, finally, to the highly complex structural arrangments and functions of the nervous system as found in man brings to the physician in particular much usable information. There is also included in this chapter an account of the interactions of the cerebrospinal system with the autonomic and closely related endocrine system, which is likewise of clinical value.

Chapters five, six and seven are respectively devoted to "Managing Our Minds," "The Endocrine Control of the Body," and "Sex." Here one finds a vast amount of scientific information which is particularly of interest to the physician.

"Democracy as a Biological Problem" is likewise an intriguingly interesting treatment of the broad general importance of biologic problems and the extent to which these figure in the social life of mankind. The author points out that since it means essentially government controlled by the majority of mankind in a community, the quality of mankind becomes an important aspect of democracy. Inherited biologic defects which impair the quality of human beings, therefore, are serious problems that warrant careful thinking and a definite program if we are to achieve satisfactory self government by group action.

The chapter entitled "The Educated Failure" has value since it comes from the pen of a person who has had a long experience as an educator with keen powers of observation.

The final chapter entitled "Man's Search for the Ideal" reveals the author as a philosopher and must be read in order to be appreciated. Without any doubt he has in mind the medical profession as a leading agency by which man may reach the goal of "health and happiness." Certainly no group or profession is as likely to see eye to eye with him in the material presented and the methods that are proposed.

The Wisconsin physician familiar with the outstanding scientific achievements of the author, more especially the many who were his students in basic science, are likely to find another facet of his personality in this book. Freed from the inherent restraints of purely scientific literature, he reveals a broad scope of thinking. There is evidence of joy in the job; figuratively, he takes necessary elbow room, and in that frame of mind expresses his broad and sound convictions without fear, let the chips fall where they may. The scientist remains well intact and the philosopher emerges—a combination which some self-acclaimed philosophers, incidentally by the same process the most vociferous, maintain is incompatible.

This book is recommended to physicians as a source of information and inspiration with the further warning that it will not serve as a soporific; its pharmacologic effect upon the medical mind is more like benzedrine and least like a barbiturate.
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PROGRAM

Friday—May 7

Business Meeting ..... 3 p.m.

Board of Directors Meeting ..... 5 p.m.

Annual Dinner ..... 6:30 p.m.

DR. ROBERT HUGHES PARRY
Medical Officer of Health, Bristol, England

Dr. Eben J. Carey ____ Toastmaster
Dean, Marquette University School of Medicine

Saturday—May 8

General Session—Morning

Theme—Tuberculosis Rejectees

Speakers—

Dr. Carl N. Neupert, State Health Officer

Miss Dorothy Paull, WATA Social Service Dept.

Capt. William Stearns, Assistant, Tuberculosis Section, Medical Corps, Office of Surgeon-General (Tentative)

Sectional Luncheons—12:15 p.m.

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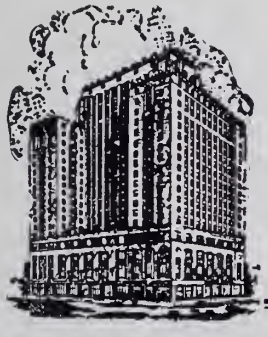

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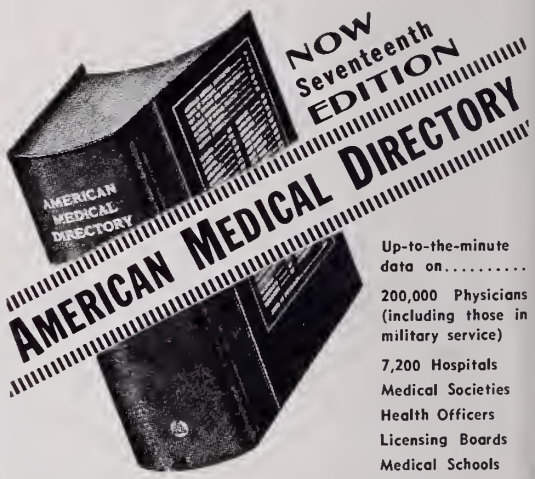

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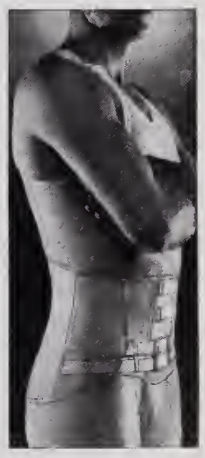

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A supplement to The Wisconsin Medical Journal, Vol. 42, No. 4, April, 1943

The method recently put into use by the members of the Dane County Medical Society in cooperation with the Dane County War Price and Rationing Board is presented herewith for use by any other similar groups of physicians. The provisions for food rationing for the civil population of the United States include a plan by which the physician may secure special consideration for any patient who requires a therapeutic diet. It is required that the physician shall specify the amounts in pounds of the processed foods, or of meats, etc., which are needed for a period of sixty days to fulfill the diet prescription which he deems necessary. He must also show cause why his patient cannot use unrationed foods, such as fresh fruits and vegetables or fish and fowl which are not covered by rationing restrictions. It will be obvious that in most cases the answer is one of the great cost which would be entailed where the diets specified must contain unusually large portions of these foods, as in diabetes mellitus, the reduction of obesity, the control of gastrointestinal disorders.

It seems probable that the rationing authorities in each of the communities will be reasonable in allowing use of a major fraction of fruits, vegetables, and meats from rationed types of foods. This will undoubtedly have to vary with seasonal changes in supply, local availability of materials such as fresh fruits in rural markets, and with the other needs of the entire country. It will simplify the task of the physician and of the rationing authorities if the requests are made in terms of the total needs. The rationing officers will make such allowances as they find possible. Milk and cream have been included in case they should be subject to rationing in the future.

In Dane County the cooperation of the dietitians from the hospitals in Madison is making it possible for individuals who have any difficulties in these adjustments to confer during one afternoon of each week with an experienced hospital dietitian at the office of the War Price and Rationing Board.

In the following pages are presented diet forms covering most types of therapeutic diet prescription which are used outside a hospital. There is no need to include the details employed in acute emergencies or for hospital practice only. The diet forms reproduced are selected from those developed and used for several years in the Wisconsin General Hospital. The numbering scheme which appears incidentally is identical with that found in the diet manual of that hospital, which has become familiar to many physicians in the state. Only in the case of diets for diabetes has there been any significant simplification. Here a single type of diet has been selected as the basis for the ration planning. This is presented in the first four pages following.

Anticipating that many physicians would welcome the simplest possible way of meeting the requirements of current national emergency, *The Journal* is reproducing these diets in the form of Supplement to the April issue. **If a complete copy of this supplement is desired, the sixteen page reprint may be ordered from the office of the State Medical Society at a cost of 10 cents.**

These individual diet instructions have been worded so that they may be placed in the hands of the patient with a minimum of diagnostic suggestion and with adequate details to spare the physician's time. **Reprints of the individual diets may be ordered, for distribution to patients, at a cost of 5 cents for the diabetes diet, or of 5 cents for any of the other separate sheets. In quantities of twenty or more of these sheets, a reduction of 50 per cent will be made.**

In submitting a request to the local rationing authorities, it is suggested that some such form as given below be followed.

To the War Price and Rationing Board,

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At the request of my patient, ----------

----------, I hereby certify that for proper treatment of an illness of chronic type a special diet is necessary. I have provided detailed directions for this dietary care. The maximum requirements for a period of sixty days are estimated below. In view of the unusually large requirements of several of these items as compared with the ordinary diet it would be an unjustified economic hardship to expect these foods to be supplied from unrationed foods in the same proportion expected of persons not on a special diet.

---------- M. D.

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Processed vegetables	pounds
Meat	pounds
Butter	pounds
Cream	pints
Milk	pints

FOOD RATIONING APPLIED TO DIABETIC DIETS

In order to simplify the task of rationing by the point system, it is suggested that diabetics be treated essentially on one type of diet which has a daily allowance of 150 grams of carbohydrate. The scheme suggested here is based on a diet of that type used for some time past in the Wisconsin General Hospital. On the succeeding pages will be found the details, planned for physician and patient. The calorie value of the diet must be varied by adjusting the fat content from the 100 gram value upward until weight is maintained at the desired level. Such alteration in fat will not affect sugar tolerance or the need for insulin.

If the physician wishes to use a diet with lower carbohydrate content, that may be done by reducing the amounts of fruits, vegetables, or bread. Unless he wishes a low calorie diet, he will find it necessary to increase the fat allowance. With restrictions on butter supply, this is a questionable gain, save that in some cases it will enable the diabetic to avoid use of insulin. In general, it may be noted that if an increase of 20 grams of fat per day is ordered, the rationing must be based on an increased allowance of three pounds of butter per two months period.

If a liquid diet is required for any reason, use may be made of the detailed scheme shown on the fourth page. Disregard of the amounts of protein and fat is warranted, since this scheme would be used for only very brief periods of time. The equivalence of carbohydrates in the two diets, plus the division of the liquids into six feedings, will make it unnecessary to adjust the insulin dose when going on or off the liquid diets.

For those diabetics who for any reason cannot be taught to weigh or measure a diet with accuracy, it is suggested that the directions for reducing diets be secured. These provide use of carbohydrate in totals of 70, 126, or 136 grams, with protein at 50 or 75 grams daily. To this diet fat may be added, just as shown for Diet A on the next page of this folder. The use of the reducing diet sheet may be combined with this set of instructions without inconsistency. The rationed portions will then be requested as on the reducing diets.

Whenever a diabetic patient is to be transferred from any other diet to the use of Diet A, the change is made without any intermediate steps. If insulin is being used it *must* be adjusted upward in dose in case the urine shows acetone bodies. It *may* be wise to adjust it upward if there is significant glycosuria. The insulin dose *must* be adjusted downward if insulin reactions occur without omission of food or excessive exercise as explanations. It is still considered the best policy to keep the urine free from sugar most, if not all the time, in most diabetics.

These directions are not to be considered as substitutes for any text for the guidance of diabetics. It is still considered important that each patient have a printed guide for use, supplementing that as suggested here for the period of food rationing.

Learning to Measure Foods Without Scales

Most diabetic patients do not need insulin. Those who do use insulin must be particularly accurate in the measurement of all food. Usually scales are necessary, at least for a time, to secure accurate measurement. After some practice with the scales, it will become possible to estimate very closely with the eye, the fingers and the use of kitchen utensils many of the food portions to be used.

It is almost never safe to allow a diabetic to begin measuring his diet in any other way than by the scales. When practice makes the scales unnecessary they may be omitted. But whenever a change in menu is made or some unfamiliar food is used, the scales must be used again. It is wise to check up on one's honesty by using the scales frequently, even after years of experience.

30 grams	1 ounce
16 ounces	1 pound
1 pint	1 pound
2 cups	1 pint
5 grams	1 teaspoon
3 teaspoons	1 tablespoon
1 cup	8 ounces or 16 tablespoons
2 tablespoons	1 ounce

The use of Diet A will require not more than the amounts of foods shown below. These are listed as amounts for sixty days. The plan is for the use of canned vegetables and fruits, which corresponds to the way in which these materials are weighed when served. Since rationing does not apply to fresh fruits and vegetables, one must subtract from the amount of fruit or vegetables mentioned below that which is allowed by the rationing board. The balance is then to be made up from home canned products or from fresh fruit and vegetables. In the latter case, of course a larger number of pounds will be required. The proportion of the total allowed under point rationing will vary with seasonal supplies, military needs, etc., but the totals given here apply so long as the diet is not altered. The physician should specify merely the total pounds needed. The rationing board will allow a certain portion of this total.

The pounds of meat required have been calculated from the total of bacon and lean meats in the diet. This has been increased sufficiently to allow for the losses due to bone, fat, and the shrinkage in cooking. This meat ration will include eggs, cheese, and the fowl and fish which are not rationed. If eggs are to be used regularly, plan on five dozen eggs per two months, and subtract four pounds of meat from the total. In addition, it is safe to plan that fish and fowl will provide for one fourth of the meat total, requiring ration points for only the remaining three fourths. Bacon accounts for not over one tenth of the meat total.

If mayonnaise is used, the amount is to be subtracted from the butter totals, and mayonnaise and butter are used interchangeably, so far as fat and calorie values are concerned.

The amounts of milk and cream are listed in case it should become necessary to place them under rationing control.

The maximum requirements for sixty days, for all these diets, A to F are:

Fruits, 40 pounds
Vegetables, 80 pounds
Meats, 40 pounds
Milk, 30 pounds, or 15 quarts

For varied calorie value select from the table below the appropriate amounts of butter and cream.

Diet	Butter	Cream
A	4½ pounds	15 pints
B	7½ "	15 "
C	8½ "	20 "
D	12 "	20 "
E	14 "	24 "
F	15 "	34 "

Diet A—1770 Calories

Food	Portion gm.	Prot. gm.	Fat gm.	Carbo. gm.
Breakfast:				
3% Fruit	500	--	---	15
Cooked cereal	100	3	--	12
Bacon	20	3	10	----
Bread	30	3	---	16
Butter	10	----	9	----
20% cream	75	2	15	3
Total		11	34	46
Dinner:				
Lean meat	90	23	14	----
3% fruit and vegetable	1000	----	---	30
Bread	30	3	---	16
Butter	15	----	13	----
20% cream	40	1	8	2
Total		27	35	48
Supper:				
Lean meat	90	23	14	----
3% fruit and vegetable	1000	----	----	30
Bread	30	3	----	16
Butter	10	----	9	----
Milk	200	6	8	10
Total		32	31	56
Total for Day		70	100	150

Diet B—with 120 grams of Fat—1950 Calories

Add 20 grams of butter or mayonnaise to Diet A

Diet C—with 140 grams of Fat—2130 Calories

Add 35 grams of butter or mayonnaise
and 45 grams of 20% cream to Diet A

Diet D—with 160 grams of Fat—2310 Calories

Add 60 grams of butter or mayonnaise
and 45 grams of 20% cream to Diet A

Diet E—with 180 grams of Fat—2490 Calories

Add 75 grams of butter or mayonnaise
and 75 grams of 20% cream to Diet A

Diet F—with 200 grams of Fat—2670 Calories

Add 80 grams of butter or mayonnaise
155 grams of 20% cream
and 10 grams of bacon to Diet A

The diet plans here given are prepared for the use of 3 per cent fruits and vegetables. This does not mean that those fruits and vegetables in the higher per cent groups cannot be used. For variety the amount of 3 per cent fruit and vegetable allowed in the diet may be replaced by half as much from the 6 per cent group, one third as much from the 9 per cent group, one fourth as much from the 12 per cent group, one fifth as much from the 15 per cent group, or one sixth as much from the 18 per cent group. (See foot-note to Table 1.) Since fruits and vegetables are classified together in the diet plan, in order to have both fruit and vegetable at a given meal, a certain portion must first be reserved for fruit, then the remainder taken as vegetables. Thus, if the allowance were 500 grams of 3 per cent fruit or vegetable, 200 grams might be used as fruit, and the remaining 300 grams as vegetable. The bread used in the menus in this book is either white, graham (whole wheat), or rye bread. The differences between these types of bread are negligible for the purposes of diet regulation in diabetes.

Fruits

Only fresh fruits or fruits which have been canned without sugar may be used. Dried fruits are not to be used, because of the variable composition. Only that part of the fruit which can be eaten is to be weighed. Therefore all seeds and stones should be removed, and fruits such as oranges should be pared. If fresh fruit is to be stewed or baked, it should be weighed raw, then water added and cooked. Both juice and fruit should be served. In weighing water pack fruit, the fruit only is weighed, and a small amount of the juice added afterward. In weighing fruits which are canned in their own juice, both the fruit and juice are weighed.

Vegetables

Vegetables are either used raw or boiled in salted water. Raw vegetables are to be cleaned and prepared so that only that portion which can be eaten is weighed. Cooked vegetables are to be weighed after cooking. A portion of the butter or cream allowed on the diet may be added if desired for flavor. Vegetable soup may be made by adding weighed cooked vegetables to fat-free broth.

Meats

Meats may be boiled, roasted or broiled without the addition of flour, cracker crumbs or gravies. Or they may be fried in a portion of the butter allowed on the diet. Meat is weighed after cooking, and only that portion which can be eaten is weighed. Only lean meat, as a rule, is to be eaten.

Bed-Time Lunch

Patients who use large doses of protamine insulin often find that a dose of insulin which is great enough to prevent the appearance of sugar throughout the day will cause an insulin shock during the night, or before breakfast the following morning. For such diabetics it is recommended that a lunch be taken at bed-time. In some cases this may be added to the menu as given, but unless permission for such an addition has been granted specifically, it is understood that the bed-time lunch is made up from the food allowances of the menus as printed. A convenient and simple lunch can be prepared by use of 30 grams of bread with 5 to 10 grams of butter. A sandwich can be made by use of one egg, or 25 grams of lean meat, or 20 grams of cheese. With this may be taken 100 grams of milk (one half cup). This lunch contains the following food values: protein 13 grams, fat 15 grams, carbohydrate 20 grams.

TABLE 1

FRUITS* AND VEGETABLES, CLASSIFIED AS TO CARBOHYDRATE CONTENT

Group I: 3% Carbohydrate	Group II: 6% Carbohydrate	Group III: 9% Carbohydrate
Asparagus, fresh & canned	Beans, green or wax, fresh	Apple sauce
Bamboo shoots	Beets, canned	Apricots, canned, w. p.
Beans, green and wax, canned	Blackberries, canned, w. p.	Artichokes, Globe or French
Beet greens	Blackberry juice	Beets, fresh
Broccoli	Carrots, canned	Blackberries, fresh
Cabbage	Celery root or celeriac	Brussels sprouts
Cabbage, Chinese or celery	Chayote, fruit	Carrots, fresh
Cauliflower	Chives	Cherries, red or white, canned, w. p.
Celery	Collards	Cranberries
Chard	Dandelion greens	Currants, fresh
Chicory, leaves	Eggplant	Currant juice
Cucumbers	Gooseberries, canned, w. p.	Gooseberries, fresh
Dock	Kale	Grapefruit, fresh and canned, w. p.
Endive	Kohlrabi	Grapefruit juice
Fennel	Lambsquarters	Lemons
Lettuce	Leeks	Lemon juice
Mungbean sprouts	Muskmelon, including cantaloupe, honeydew, Spanish melon	Limes
Mustard greens	Okra, fresh	Lime juice
Okra, canned	Peaches, canned, w. p.	Limes, sweet
Poke shoots	Peppers, green and red	Loganberries, canned, w. p.
Purslane	Plums, canned, w. p.	Loganberry juice
Radishes	Pumpkin, cooked	Onions
Rhubarb, fresh and canned, w. p.	Squash, queen, pipper or winter	Papayas
Romaine	Strawberries, fresh	Pears, canned, w. p.
Sauerkraut	Strawberry juice, fresh	Peas, canned
Seakale	Tomato puree, canned	Raspberries, canned, w.p.
Sorrel	Turnips, fresh or canned	Raspberry juice
Spinach, fresh and canned	Watermelon	Rutabagas
Squash, Summer		Tangerines
Strawberries, canned, w. p.		
Tomatoes, fresh and canned		
Tomato juice, fresh and canned		
Turnip tops, fresh and canned		
Vegetable marrow		
Watercress		

Group IV: 12% Carbohydrate	Group V: 15% Carbohydrate	Group VI: 18% Carbohydrate
Apple juice, fresh or canned	Apples, fresh	Beans, red kidney, canned
Apricots, fresh	Blueberries, fresh and canned, w. p.	Cherries, fresh
Beans, Lima, canned	Blueberry juice	Corn, canned
Cherries, red, fresh	Figs, canned, w. p.	Crab apples, fresh
Grapes, canned, w. p.	Grapes, fresh	Grape juice, unsweetened
Guavas	Jerusalem artichokes, tubers	Persimmons, Japanese
Mulberries	Kumquats	Pomegranates
Oranges	Loganberries, fresh	Potatoes
Orange juice	Mangoes	Succotash, canned
Peaches, fresh	Nectarines	
Peach juice	Parsnips, fresh or canned	
Pineapple, fresh and canned, w. p.	Pears, fresh	
Pineapple juice	Peas, fresh	
Plums, fresh	Salsify	
Prunes, canned, w. p.	Vegetable-oyster	
Raspberries, black and red, fresh		

* The canned fruits included here are all water-packed products, designated as "w.p." in the lists.

As a Substitute For 100 Grams of a 3 Per Cent Fruit or Vegetable, Use:

From group II (6%) ---------- 50 grams; or
From group III (9%) ---------- 33 grams; or
From group IV (12%) ---------- 25 grams; or
From group V (15%) ---------- 20 grams; or
From group VI (18%) ---------- 17 grams.

Use of Canned Foods

Since the use of fresh vegetables and fruits is not economical at all times of the year, the canned foods may be used when they are cheaper to buy. Canned vegetables need not be bought in special packs. These foods are cooked in the cans, with no sugar added to the vegetable. The use of peas in diabetic diets calls for special calculation because of the large amount of carbohydrate in them. It is simpler to omit them entirely. Dried fruits such as apples, prunes and apricots are sometimes economical but they are not advisable for use by the diabetic. This is because of the variable amount of sugar in the fruit when it has been cooked, depending upon how much water has been added and on how far the fruit is boiled down. Figures for the carbohydrate content of dried fruits prepared for use are not reliable. Therefore it is urged that dried fruits be omitted from the menus of the diabetic.

The canned vegetables are to be used like the vegetables which have been cooked at home. That is, the water in the can is used in cooking the food and then it is poured off, and the same amount of vegetable used as if the raw weight had been taken.

In the case of the fruits it is the custom to add sugar in the canning process. The amount of sugar often varies widely between cans of different brands. There are some fruits canned with the use of nothing more than water. The sugar is not at all necessary for the preservation of the fruit. Usually these cans which contain no added sugar are labeled "pie fruit" or are called water packs. In some cases this fruit is of the smaller or the irregular sizes. It is consequently cheaper than the fancier grades of the same packer's product. These fruits are perfectly good food.

In using water pack or pie fruits, use the weight of fruit called for in the diet, and add the amount of juice from the can which apparently goes with this amount of fruit. The juice contains sugar which has dissolved out of the fruit.

TABLE 3
MEAT EQUIVALENTS

Meat	Chicken	Fish		Liver and Bacon		Eggs and Bacon			Cottage Cheese			Cream Cheese	
Lean meat, gm.	Chicken (boiled) gm.	Fish, gm.	Add butter, gm.	Liver, gm.	Bacon, gm.	Eggs,	Bacon, gm.	Omit butter, gm.	Cottage Cheese, gm.	Add butter, gm.	Omit 3% fruit or vegetable, gm.	Amer., Cream, or Swiss Cheese, gm.	Omit butter, gm.
100	145	140	9	100	30	------	------	------	120	17	150	92	20
95	140	135	8	100	25	------	------	------	115	16	150	88	19
90	135	130	8	100	20	------	------	------	110	16	150	84	19
85	125	120	8	95	15	------	------	------	100	15	150	78	17
80	115	110	7	85	20	------	------	------	95	13	150	75	17
75	110	105	7	80	20	------	------	------	90	12	150	70	16
70	105	100	7	75	20	2	35	22	85	12	100	67	15
65	95	90	7	65	20	2	25	18	75	11	100	60	13
60	90	85	6	60	20	2	20	15	70	10	100	56	12
55	85	80	5	55	20	2	15	14	65	8	100	52	12
50	75	70	5	50	20	2	10	10	60	8	50	46	11
45	65	60	5	40	20	1	30	16	50	7	50	42	9
40	60	55	4	40	15	1	25	15	48	7	50	38	9
35	55	50	3	35	15	1	20	12	42	5	50	34	8
30	50	45	3	30	15	1	10	8	35	5	50	28	6
25	40	35	2	25	10	1	0	3	30	5	50	22	5

BREAD SUBSTITUTIONS

In place of 15 grams of bread, any one of the following items may be used:—

Cereals, cooked 1 part in 4 parts of water, 65 gm.
Dry cereals, 11 grams.
Crackers, soda or graham, 12 grams.
Potato, 40 grams.
Green corn, 40 grams.
3 per cent fruit or vegetable, 300 grams.

The liquid diets are for use during emergencies only. Such occasions are after removal of several teeth, removal of tonsils, stomach disturbances, or when recovering from operations or fevers. It is often advisable to divide these liquid diets into more than 3 feedings. The number of times when food is given in the day may be varied as much as seems desirable. The cereals are to be cooked as usual, 1 part of dry cereal in 4 parts of water, and then they are to be thinned with warm milk to make liquid gruels. Cream is used with coffee, since it is understood that in addition to the foods listed here, coffee, tea, or clear broth may be used. If desired, the whole egg may be used instead of the egg whites mentioned, since this adds only a little fat. Or if the egg yolk is not well taken, all the eggs may be used without the yolks.

Eggs

An egg may be used as a substitute for 25 grams or 1 ounce of meat.

SAMPLE MENU OF A LIQUID DIET IN SIX MEALS

(Carbohydrate 150 gm.)

Breakfast:
Gruel, made with:
Cooked cereal ---------- 100 gm.
Milk ---------- 100 gm.
Orange juice ---------- 200 gm.
Tea

10 A. M.:
Orange juice ---------- 200 gm.

Dinner:
Cream Soup, made with:
Tomato Puree ---------- 60 gm.
Milk ---------- 100 gm.
Milk ---------- 200 gm.

3 P. M.:
Eggnog, made with:
Eggs ---------- 2
Milk ---------- 150 gm.
Vanilla ---------- ¼ tsp.
Orange juice ---------- 150 gm.

Supper:
Broth ---------- 200 gm.
to which add:
Egg whites ---------- 2
Custard, made with:
Egg ---------- 1
Milk ---------- 100 gm.
Vanilla ---------- ¼ tsp.
20% Cream ---------- 40 gm.
Coffee
Orange juice ---------- 200 gm.

8 P. M.:
Milk ---------- 200 gm.

DIETS 19, 20 and 21

Less food is furnished by these diets than the individual needs for maintenance, so that excessive body fat will be utilized. In order to make this procedure safe for health, it is necessary that the foods listed should be eaten in the portions given. These diets are adequate to prevent any form of deficiency disease. Diets 19, 20 and 21 are provided for different types of individuals; use only the one directed. An alternate menu for Diet 20 is included for the use of those who must economize. Substitution of more milk and potato for fruits and part of the meat leaves the diet safe for continued use.

Variety is secured by choosing on different days the various vegetables and fruits. Where "3 portions" of vegetables are mentioned it is understood that all 3 portions may be taken of any one vegetable; if two or three vegetables are available, 1 portion may be served from each to increase the variety. Vegetables should be served without cream sauce, or butter other than that listed in the diet.

Fruits should be fresh or those which are canned without sugar. No sugar should be added to fresh fruits in cooking them.

Vegetables and fruits may be taken as salads if desired. Vinegar or lemon juice may be used.

Buttermilk may be used instead of sweet milk if preferred. Whole wheat bread is preferable to white or rye bread; bran bread should not be used unless by special direction. The bread may be toasted if desired. Sugar-free gelatin may be used; "D-Zerta" is such a preparation. In any meal, tea, coffee, consomme or broth containing no fat may be used in any amount desired.

"Dinner" and "supper" may be reversed and served as "lunch" and "dinner" if preferred. If hunger is very annoying in the mid-morning, afternoon or evening, part of any one of these meals may be eaten as a lunch at this time (and, of course, subtracted from the meals for that day).

Water may be taken freely at all times, including meals, provided it is not used to refresh the appetite and thus increase the amount of food eaten. In other words, chew the food and swallow it before drinking.

Take some sort of exercises regularly each day. Walk outdoors _____ miles each day. After four days, increase the daily walk by adding _____ miles more each day until walking _____ miles each day. Increase the speed of walking gradually. Keep a record of the weight twice weekly using page 4 of this folder.

When choosing between the standard or low cost forms of diet 20, note that the lower cost is secured by omitting fruits and reducing the amount of meat. This is done by increasing the potatoes used, and it is important that in such a situation the potatoes should be cooked in their jackets and the jackets eaten whenever possible. Even then a deficiency of vitamin C (ascorbic acid) is probable, and it may be wise to prescribe this in addition, in such amounts as 50 mgs. daily.

For any of these low calorie diets it is probably safer to give daily doses of vitamin A up to 5000 units, and vitamin D up to 500 units. If abundant green vegetables are used, A may be omitted.

The principle of the rationing is that the pounds of each food class will be requested by the physician in a note to the rationing authorities. It is expected that the authorities will allow a portion of this total in terms of points. The balance, not covered by points, must be provided from the fresh fruits and vegetables secured, from the home canned foods in stock, or from fish and fowl not included in point rationing. It is usually fair to expect that at least one fourth of meat needs of this diet can be secured from such sources. The weights of fruits and vegetables have been estimated as processed foods. Of course it will require more pounds of fresh foods, to allow for waste in preparation.

The maximum requirements for sixty days for these diets, 19, 20, or 21, are given in pounds below:

Food group	Diet 19	Diet 20 Standard	Diet 20 Low cost	Diet 21
Fruits	32	36	--	36
Vegetables	54	75	75	75
Meat	20	20	15	30
Butter	2½	4	4	4
Potatoes	--	12	54	12
Eggs	5 doz.	5 doz.	5 doz.	5 doz.
Skim milk	36 pts.	48 pts.	48 pts.	54 pts. (whole)

Protein 50 grams, Carbohydrate 126 grams, Fat 55 grams; Calories 1200.

STANDARD

Breakfast

Bread 1 slice
or
Cooked cereal ¾ cup
Sugar 1 teaspoon
Butter 1 pat
Egg 1
Skim milk 1 cup
Fruit 1 portion

Dinner

Lean meat 1 small serving
Potato 1 portion
Vegetables 3 portions
Bread 1 slice
Butter 1 pat
Fruit 1 portion

Supper

Lean meat 1 small serving
Vegetables 3 portions
Bread 1 slice
Butter 1 pat
Fruit 1 portion
Skim milk 1 cup

DIET 19

Protein 50 grams, Carbohydrate 70 grams, Fat 50 grams; Calories 930.

Breakfast

Fruit 1 portion
Egg 1
Bread ½ average slice
Butter 1 pat
Skim milk ½ cup

Lunch

Lean meat 1 small serving
Vegetables 2 portions
Bread ½ average slice
Butter ½ pat
Fruit ½ portion
Skim milk ½ cup

Dinner

Lean meat 1 small serving
Vegetables 2 portions
Bread ½ average slice
Butter ½ pat
Fruit 1 portion
Skim milk 1 cup

LOW COST DIET

Breakfast

Bread 1 slice
or
Cooked cereal ¾ cup
Sugar 1 teaspoon
Butter 1 pat
Egg 1
Skim milk 1 cup

Dinner

Lean meat 1 average serving
Potatoes 2 portions
Vegetables 3 portions
Bread 1 slice
Butter 1 pat

Supper

Potato 2 portions
Vegetables 3 portions
Bread 1 slice
Butter 1 pat
Skim milk 1 cup

DIET 21

Protein, 75 grams, Carbohydrate 136 grams, Fat 73 grams; Calories 1500.

Breakfast

Fruit 1 portion
Bread 1 slice
or
Cooked cereal ¾ cup
Butter 1 pat
Egg 1
Milk (whole) ½ cup
Sugar 1 teaspoon

Dinner

Lean meat 1 average serving
Potato 1 portion
Vegetables 3 portions
Bread 1 slice
Butter 1 pat
Fruit 1 portion
Milk (whole) 1 cup

Supper

Lean meat 1 average serving
Vegetables 3 portions
Bread 1 slice
Butter 1 pat
Fruit 1 portion
Milk (whole) ½ cup

Vegetable Portions

Asparagus, cooked 14—3″ tips or ½ cup
Asparagus, fresh 8—6″ stalks
Beets, diced ¼ cup
Beet greens ½ cup
Broccoli ½ cup
Brussels sprouts 3
Cabbage, cooked ½ cup
Cabbage, raw 2/3 cup
Carrots ¼ cup
Cauliflower 2/3 cup
Celery, raw 5—7″ stalks
Celery, cooked 2/3 cup
Celery cabbage, cooked 2/3 cup
Celery cabbage, raw 1 cup
Cucumber, diced 2/3 cup
Dandelion greens ½ cup
Eggplant ½ cup
Kohl-rabi 3 tbsp.
Lettuce ¼ sm. head
Green limas, canned 3 tbsp.
Mushrooms as desired
Okra, fresh ¼ cup
Okra, canned ½ cup
Onions, cooked ½ cup
Onions, raw ¾ cup
Onions, raw—green stick 12—4″ onions
Oyster plant 2 tbsp.
Parsnips, boiled 2 tbsp.
Peas, fresh 2 tbsp.
Peas, canned 3½ tbsp.
Radishes 12 medium
Rhubarb 2/3 cup
Romaine 10 leaves
Rutabagas 2 tbsp.
Sauerkraut 2/3 cup
Sauerkraut Juice ½ cup
Spinach ½ cup
String beans, fresh ¼ cup
String beans, canned ½ cup
Swiss chard 2/3 cup
Squash, Hubbard, mashed 1/3 cup
Squash, Summer mashed 2/3 cup
Tomatoes, cooked ½ cup
Tomatoes, fresh 1 small
Tomato Juice ½ cup
Turnips 3 tbsp.
Watercress 2 cups

Potato

1 portion of potato is ½ small potato, a piece the size of a small egg; it may be substituted by:
Red Kidney Beans ¼ cup
Corn, canned 3 tbsp.
Fresh limas 1/3 cup

Fruit Portions

Apple, raw 2/3 sm. apple
Applesauce ½ cup
Apricots 4 halves
Banana 1/3 medium
Blackberries fresh ¾ cup
Blackberries canned ¾ cup
Blueberries fresh ½ cup
Blueberries, canned 1/3 cup
Cherries, red pitted canned ½ cup
Cherries, Royal Ann 18 cherries
Cherries, fresh red ½ cup
Cherries fresh black 1/3 cup
Gooseberries 2/3 cup
Grapefruit, fresh ½ medium or 6 sections
Grapefruit, canned 6 sections
Grapefruit juice ½ cup
Grapes, fresh 10 grapes
Grape juice 1/3 cup
Loganberries, fresh 2/3 cup
Loganberries, canned 1 cup
Melon, cubed 1 cup
Oranges 1 small
Orange Juice ½ cup
Peach, fresh ½ medium
Peach, canned—
halves 2 halves
sliced 1/3 cup
Pears, fresh ½ pear
Pears, canned 2 halves
Pineapple, fresh or canned
diced ½ cup
sliced 1¼ slices
Pineapple juice ½ cup
Plums 3 plums
Prunes 3 prunes
Raspberries, fresh 1 cup
Raspberries, canned ½ cup
Strawberries, fresh 1¼ cup
Strawberries, canned 1½ cup
Tangerines 2 medium

Cheese Portions

American cheese 2 ounces
Cottage cheese, dry ½ cup
Cream cheese 2 ounces

Meat

1 small portion of meat weighing 2 ounces, or the size of an egg, may be substituted by:

1 average serving of fish or chicken, or 1 portion of cheese, or 2 eggs.

1 average portion of meat weighing 3 ounces, or the size of one and a half eggs, may be substituted by:

1 large serving of fish or chicken, or 2 portions of cheese, or 3 eggs.

In order to secure special allowance of foods from the rationing authorities the physician will request the total number of pounds of each class of foods required for sixty days. In the case of the fruits and vegetables this is given in terms of the processed foods, or in other words as cooked foods, ready to serve. It is expected that the allowances will not provide for all this amount. The difference is to be made up from fresh fruits and vegetables, from home canned foods, and allowance will have to be made for larger weights of fresh foods to allow for waste in preparing them. Whenever pureed foods are required in the diet, there will also be some loss.

The amounts of meat have been calculated to allow for bone, fat, and for the shrinkage during cooking. This is assumed to be not over one fourth total. The ration allowances will not provide for all this meat. The difference is to be made up from fish and fowl which are not included in rationing restrictions. It is considered safe to make such sources of meat provide for at least one fourth of the total meat supply listed.

If eggs are used as meat substitutes, plan to replace one ounce of meat by one egg. Similarly an ounce of fish or of cheese may be used as a meat substitute. For the daily use of an egg as meat substitute, it is safe to reduce the meat allowance by four pounds for each sixty days.

Mayonnaise may be used in the same amounts as butter, and is a satisfactory substitute so far as calorie value is concerned, although mayonnaise contains far less vitamins than butter.

The maximum requirements for sixty days for this diet are as follows:

Food requirements for diet 30

Fruits	50 pounds
Vegetables	35 "
Potatoes	25 "
Meat	26 "
Butter	4 "
Cream	8 pints
Milk	75 pints

DIET 30

Water is important. Take at least eight glasses per day always when the stomach is normally empty. Two glasses 20 to 30 minutes before breakfast, two or three glasses in the late forenoon, the same in the late afternoon, and about one glass in the evening.

Exercises, as ordered by physician.

DIET

FOODS ALLOWED

Soups:	Consomme, chicken broth, beef broth, strained or pureed vegetable or cream soup, or any simple soup which is not highly seasoned.
Meats:	Once daily: the inside cut of roast beef, veal, or lamb; broiled beef, veal, or lamb in the form of steaks, chops or patties; crisp bacon; fish, fowl, sweetbreads or liver, prepared any way except fried or sauteed.
Eggs:	Boiled, poached, scrambled, creamed, baked, souffles, or omelettes.
Cheese:	Cottage, Philadelphia cream, or mild American or Swiss.
Vegetables:	White potatoes may be boiled, baked, mashed, creamed, scalloped or au gratin. Sweet potatoes must be pureed.
	At least two servings of other vegetables daily:
	Cooked: Asparagus tips, beets, carrots, and squash.
	Cooked and pureed: Asparagus stalks, beet greens, celery, corn, lima beans, mushrooms, peas, spinach, string beans, Swiss chard, and tomatoes.
Fruits:	At least two servings daily:
	Canned: Grapefruit, peaches, pears, red cherries, white cherries, and apricots (without skins).
	Baked: Apples, bananas, peaches, pears, (without skins or seeds).
	Purees: Stewed apricots, stewed prunes, canned plums.
	Juice of fresh or cooked fruits may be used.
Salads:	Made of any foods allowed, with whipped cream dressing. A small amount of lettuce may be eaten, if well chewed.
Desserts:	Simple cakes, custards, vanilla ice cream, Jello, Junket, tapioca puddings, cornstarch puddings, rice puddings, bavarian cream puddings, fruit whips, fruit puddings (see above).
Bread:	White, light whole wheat or light rye, preferably one day old or toasted. Soda crackers and graham crackers are allowed.
Cereals:	Any cooked cereal. Any dry cereal except those containing much bran.
Cream:	As desired.
Butter:	As desired.
Beverages:	Milk, buttermilk, malted milk, eggnog, Ovaltine, cocoa, Postum, Sanka or Kaffee Hag coffee, weak tea, fruit juice.
Miscellaneous:	Hominy, macaroni, noodles, spaghetti, polished rice (without stimulating sauces), honey, jelly, syrup.

FOODS NOT ALLOWED

Fried foods, gravy.
Relishes, pickles, olives, spices, and highly seasoned foods.
Nuts.
Ice cream, ices, iced beverages and carbonated beverages.
Hot breads, biscuits, waffles, muffins, etc.
Shell fish, except clams and oysters.

SAMPLE MENU

Approximate food value: P—80, F—120, C—240, Calories—2360

Breakfast:	Dinner:	Supper:
Orange Juice, ½ c.	Broiled Steak, ave. serving	Tomato Juice, ½ c.
Wheatena, ¾ c.	Mashed Potatoes, ½ c.	Omelet, ave. serving
Cream, ¼ c.	Buttered Carrots, ½ c.	Baked Potato, 1 med.
Sugar, 1 T.	White Bread, 1 sl.	White Bread, 1 sl.
White Toast, 1 sl.	Butter, 1 pat	Butter, 1 pat
Butter, 1 pat	Tapioca Pudding, ½ c.	C. Peaches, 1 half
Cocoa, 1 c.	Milk, 1 gl.	Angel food, 1 serv.
		Milk, 1 gl.

The caloric level may be adjusted by adjusting the size of the servings

In order to secure special allowance of foods from the rationing authorities the physician will request the total number of pounds of each class of foods required for sixty days. In the case of the fruits and vegetables this is given in terms of the processed foods, or in other words as cooked foods, ready to serve. It is expected that the allowances will not provide for all this amount. The difference is to be made up from fresh fruits and vegetables, from home canned foods, and allowance will have to be made for larger weights of fresh foods to allow for waste in preparing them. Whenever pureed foods are required in the diet, there will also be some loss.

The amounts of meat have been calculated to allow for bone, fat, and for the shrinkage during cooking. This is assumed to be not over one fourth total. The ration allowances will not provide for all this meat. The difference is to be made up from fish and fowl which are not included in rationing restrictions. It is considered safe to make such sources of meat provide for at least one fourth of the total meat supply listed.

If eggs are used as meat substitutes, plan to replace one ounce of meat by one egg. Similarly an ounce of fish or of cheese may be used as a meat substitute. For the daily use of an egg as meat substitute, it is safe to reduce the meat allowance by four pounds for each sixty days.

Mayonnaise may be used in the same amounts as butter, and is a satisfactory substitute so far as calorie value is concerned, although mayonnaise contains far less vitamins than butter.

The maximum requirements for sixty days for this diet are as follows:

Food requirements for diet 31

Fruits	50 pounds
Vegetables	50 "
Potatoes	13 "
Meat	15 "
Cheese	3 "
Eggs	6 dozen
Butter	4 pounds
Cream	8 pints
Milk	60 pints
Jam	4 pounds

ATONIC CONSTIPATION

DIET 31

This diet is intended to combat the common type of atonic constipation.

Water is important. Take at least eight glasses per day, always when the stomach is normally empty. Two glasses 20 to 30 minutes before breakfast, two or three glasses in the late forenoon, the same in the late afternoon, and about one glass in the evening.

Exercise as directed by the physician.

No restriction in the quality of food except in so far as specific foods have been found to repeatedly disagree. The aim of this diet is to increase bulk and curtail the quantity of foods which have little or no residue.

Foods to be included in the diet:

1. Fruit: Take at least four servings daily.

   Include fruits with skins and seeds, raw or cooked. A part may be in the form of salads if desired.

2. Vegetables: Take at least four servings daily (including potato).

   Raw vegetables (e.g., celery, lettuce, etc.) or cooked may be chosen. A part may be in the form of salads if desired.

3. Bread: Whole wheat bread, graham bread or bran muffins should be used in preference to white.

4. Breakfast cereals: Whole grain cereals should be used in preference to refined cereals.

   Caution: Excessive use of extremely coarse dry cereal may be harmful.

5. Lean meat, fish, chicken, eggs, cheese, or other meat substitutes: Two small servings daily.

6. Milk: 2 glasses daily. A part of this may be made into milk soups.

7. Liberal amounts of jam, berries, figs, dates and raisins should be used.

8. Beverages: Liberal amounts of liquids including soups.

Foods to be taken sparingly:

Butter, cream, oil salad dressings, or high fat foods of any kind; concentrated sweets except those mentioned above in No. 7.

Foods to be omitted:

All pies, pastries, ices, ice cream, cakes, white bread, fresh bread, refined breakfast cereals, gravies, and cream sauces.

SAMPLE MENU

Approximate food value: P–55 gms., F–90 gms., C–265 gms., Calories—2090

Breakfast:

Stewed prunes	5
Oatmeal with Raisins	¾ c.
Cream with part milk	¼ c.
Sugar	1 Tbsp.
Whole wheat toast	1 slice
Butter	1 pat
Jam with seeds	2 Tbsp.
Coffee	

Dinner:

Roast beef (small serving)	2 oz.
Whole Kernel corn	½ c.
Buttered Spinach	½ c.
Apple & Orange salad without dressing	1 serv.
Rye Bread	1 slice
Butter	1 pat
Fresh Strawberries	¾ c.
Milk	1 glass
Tea	

Supper:

Baked Egg	one
Buttered Asparagus	½ c.
Sliced tomato salad without dressing	1 serv.
Whole Wheat Bread	1 slice
Butter	1 pat
Jam with seeds	1 Tbsp.
Fresh Pineapple	½ c.
Milk	1 glass

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Mayonnaise may be used in the same amounts as butter, and is a satisfactory substitute so far as calorie value is concerned, although mayonnaise contains far less vitamins than butter.

The maximum requirements for sixty days for this diet are as follows:

Food requirements of diet 32

Fruits	40 pounds
Vegetables	25 "
Potatoes	25 "
Meat	26 "
Butter	4 "
Milk	56 pints

GALL BLADDER

DIET 32

It is preferable to have the evening meal the lightest. Always avoid eating enough to bring about the sensation of fullness in the stomach. It is better to take some nourishment between meals than to overdistend the stomach. On rising in the morning, at least 20 minutes before breakfast, take about two glasses of water, either hot or cold, as desired. Always try to take about three glasses of water, morning and afternoon between meals. One glass at bedtime is sufficient. The physician should make specific recommendations about out-of-door exercise.

(Physician will strike out one):

Plan to eat 3 meals daily.
Plan to eat 5 meals daily.

In so far as possible observe the following suggestions in your diet.

FOODS ALLOWED

Soups:	Consomme, chicken broth, beef broth, vegetable or milk soup made from vegetables allowed, or any soup which is not highly seasoned and from which the fat has been removed.
Meats:	A serving of lean meat or meat substitute twice daily: the inside cut of roast beef, veal, or lamb; broiled beef, veal or lamb in the form of steaks, chops, or patties; fish, fowl, sweetbreads, or liver, prepared any way except fried or sauteed.
Eggs:	No more than one daily (omit fried)
Cheese:	Fat free cottage cheese.
Vegetables:	White potatoes may be boiled, baked, mashed, scalloped, or creamed. Sweet potatoes must be pureed. At least two servings of other vegetables daily: Cooked: Asparagus tips, beets, carrots, squash. Cooked and Pureed: Asparagus stalks, beet greens, celery, corn, green lima beans, mushrooms, peas, spinach, string beans, Swiss chard, tomatoes.
Fruits:	At least two servings of the following fruits per day: Canned: Grapefruit, peaches, pears, red cherries, white cherries, and apricots (without skins). Baked: Apples, bananas, peaches, pears, (without seeds or skins). Purees: Stewed apricots, stewed prunes, canned plums
Salads:	Made of any of the foods allowed. A small amount of leaf lettuce may be eaten, if very well chewed. Omit salad dressing.
Desserts:	Simple desserts, low in fat, such as gelatin preparations, fruit jello, ices, junket, rice, sago, cornstarch or tapioca puddings, or angel food cake.
Bread:	White, light whole wheat or light rye, preferably one day old or toasted. Soda crackers and graham crackers are allowed. Omit breads containing bran.
Cereals:	Any cooked cereal. Any dry cereal except those containing much bran.
Butter:	Very sparingly; not to exceed 3 pats a day.
Beverages:	Milk, buttermilk, postum, Sanka, Kaffee Hag coffee, weak tea, fruit juice.
Miscellaneous:	Macaroni, noodles, spaghetti, hominy, rice, honey, jelly.

FOODS NOT ALLOWED

All uncooked whole fruits and vegetables; fried foods in any form; relishes, pickles, olives, spices, and highly seasoned foods; nuts, cream, chocolate, oil dressings, ice cream, carbonated beverages, hot breads, biscuits, waffles, muffins, etc.; cheese except that listed.

SAMPLE MENU

Approximate food value: P—75 gms., F—67 gms., C—210 gms., Calories—1745

Breakfast:	Dinner:	Supper:
Baked Apple (omit skins) 1 sm.	FF Br. Steak, ave. serving	FF Beef Broth, 1 serv.
Oatmeal, ¾ c.	Baked Potato, 1 med.	Soda Crackers, 2
Milk, ¼ c.	FF Carrots, ½ c.	FF Baked Chicken & Noodles, ave. serv.
Sugar, 1 T.	White Bread, 1 sl.	FF Str. Bean Puree, ½ c.
White Toast, 1 sl.	Butter, 1 pat	White Bread, 1 sl.
Butter, 1 pat	Caramel Custard, ½ c.	Butter, 1 pat
Kaffee Hag	Milk, 1 gl.	Canned Pears, 1 half
		Milk, 1 gl.

FF—Abbreviation for fat free.

The caloric level may be adjusted by adjusting the size of the servings

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Mayonnaise may be used in the same amounts as butter, and is a satisfactory substitute so far as calorie value is concerned, although mayonnaise contains far less vitamins than butter.

The maximum requirements for sixty days for this diet are as follows:

Food requirement for diet 34 A and B

Cream	70– 90 pints
Milk	180–205 pints
Orange juice	30 pints

Vegetables and fruits, in small amounts for purees. Amounts cannot be specified in monthly terms since these are added gradually during the month or two until the individual is ready to use diet number 35. If weight is not maintained satisfactorily, these amounts may have to be increased by request of the physician.

DIET 34

The object of these diets is to control pain at all times. If there is not complete relief from pain, your physician should be consulted immediately.

Diet 34A

The basic feeding is made by mixing:

(1) 3 parts of whole milk with one part of cream

(2) 2 parts of whole milk with one part of cream
(Physician will cross out one of the above)

Three ounces of the milk and cream mixture should be taken hourly or 6 ounces every 2 hours from 8 A. M. to 8 P. M. inclusive.

In addition to the basic feeding, 8 ounces of orange juice may be taken daily. This may be mixed with the milk and cream or taken separately following the milk and cream. Sugar may be added to the orange juice if desired.

Diet 34B

The milk and cream mixture and the orange juice taken in Diet 34A is continued as above. Daily additions to the basic feeding are made at regular meal times, beginning at breakfast, then at noon, and finally at supper. These feedings are listed below in the order and forms in which they should be taken.

(1) Cereal—Cream of rice, cream of wheat, boiled rice. Cream and sugar as desired.

(2) Ice Cream (eaten slowly)—Vanilla or custard.

(3) Eggs—Prepared anyway except fried. Scrambled eggs should be prepared in a double boiler.

(4) Toast—Melba or well toasted thin white bread.

(5) Potato—Baked or mashed.

(6) Vegetable and fruit purees:

Asparagus	String Beans (green or wax)
Beets	Tomatoes
Carrots	Applesauce
Peas	Peaches
Spinach	Pears
Squash	White Cherries

(7) Simple desserts as angel food cake, sponge cake, simple puddings, custards, junkets, simple gelatin desserts, and jello.

PEPTIC ULCER—MAINTENANCE

DIET 35

Eat 3 regular meals a day with extra feedings of milk and cream (with or without the addition of orange juice) until advised otherwise by physician. It is necessary to control symptoms at all times.

FOODS ALLOWED

Soups:	Cream soups made with vegetable purees allowed, and chicken broth.
Meats:	Once daily: Chicken, fresh fish, canned salmon, sweetbreads, scraped beef, calves liver, lamb chop (prepared any way except fried or sauteed).
Eggs:	Boiled, poached, scrambled (in double boiler), baked, or creamed.
Cheese:	Creamed cottage, cream, or mild American.
Vegetables:	White potatoes may be boiled, baked, mashed, escalloped, creamed or au gratin. Sweet potatoes must be pureed. Two of the following vegetables, pureed (sieved), per day: Asparagus, beets, carrots, celery, corn, mushrooms, peas, spinach, squash, string beans (green or wax), tomatoes, canned baby foods.
Fruits:	Two of the following fruits per day: Cooked: Bananas (may be used without cooking if they are very ripe), peaches, pears, white cherries, and canned grapefruit. Cooked and pureed: Apples, apricots, plums and prunes. If desired, one half glass of any strained fruit juice may be substituted for one serving of pureed fruit.
Desserts:	Ice cream (custard or vanilla), custard, junket, tapioca pudding, cornstarch pudding, rice pudding, bavarian cream pudding, sponge cake, angel food cake, jello, fruit whip of fruit or fruit purees allowed, and simple gelatin desserts.
Bread:	Stale or toasted. Preferably white, but light rye or light whole wheat bread may be used. Soda crackers are allowed.
Cereals:	Cream of wheat, cream of rice, strained oatmeal gruel, cornflakes, puffed rice, puffed wheat, rice krispies.
Cream and butter:	As desired.
Beverages:	Milk, buttermilk, plain malted milk, eggnog, fruit juices.
Miscellaneous:	Hominy, macaroni, noodles, spaghetti (without

FOODS NOT ALLOWED

Fried Foods. Foods containing seeds and skins. Spices, relishes, pickles, olives, any highly seasoned foods. Pastries, nuts, and hot breads. Whole grain cereals or whole wheat breads. Coffee, tea, alcoholic beverages, coca cola, etc.

SAMPLE MENU

Approximate food value: P—75 gms, F—115 gms, C—230 gms, Calories—2255

Breakfast:	Dinner:	Supper:
Strained Orange Juice, ½ c.	Scraped Beef Pattie, average serving	Cream of Celery Puree Soup, ½ c.
Cream of Wheat, ¾ c.	Scalloped Potato, ½ c.	Soda Crackers, 2
Cream, ¼ c.	Buttered Beet Puree, ½ c.	Baked Egg, One
Sugar, 1 Tbsp.	White Bread (day old) 1 slice	Buttered Noodles, ½ c.
White Toast, 1 slice	Butter, 1 pat	White Bread (day old) 1 slice
Butter, 1 pat	Angel food cake, 1 serving	Butter, 1 pat
Cocoa, 1 c.	Milk, 1 glass	Applesauce puree, ½ c.
		Milk, 1 glass

10 o'clock—Milk & Cream 3 o'clock—Milk & Cream
8 o'clock—Milk & Cream

The caloric level may be adjusted by adjusting the size of the servings

The maximum requirements for 60 days for diet 35 are as follows:

Fruits	45 pounds
Vegetables	35 "
Potatoes	11 "
Meat	15 "
Eggs	5 dozen
Butter	8 pounds
Cream	[illegible]

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The Wisconsin Medical Journal

IN THIS ISSUE

MAKING RATION-LIMITED DIETS ADEQUATE
By Elmer L. Sevringhaus, M. D.

THE TECHNIC OF HOME CANNING
By Dorothy L. Hussemann

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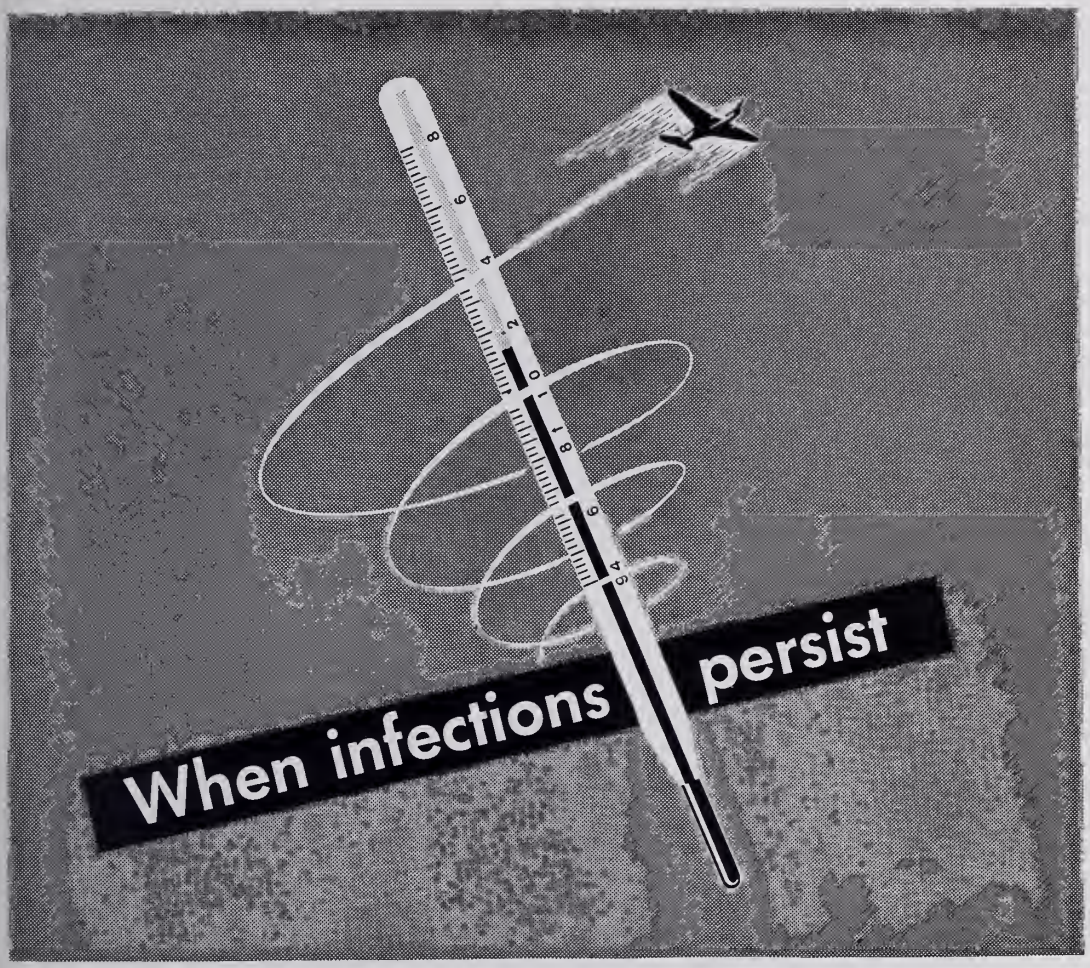

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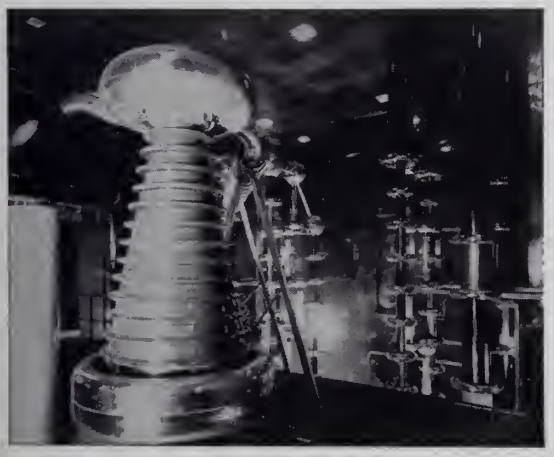

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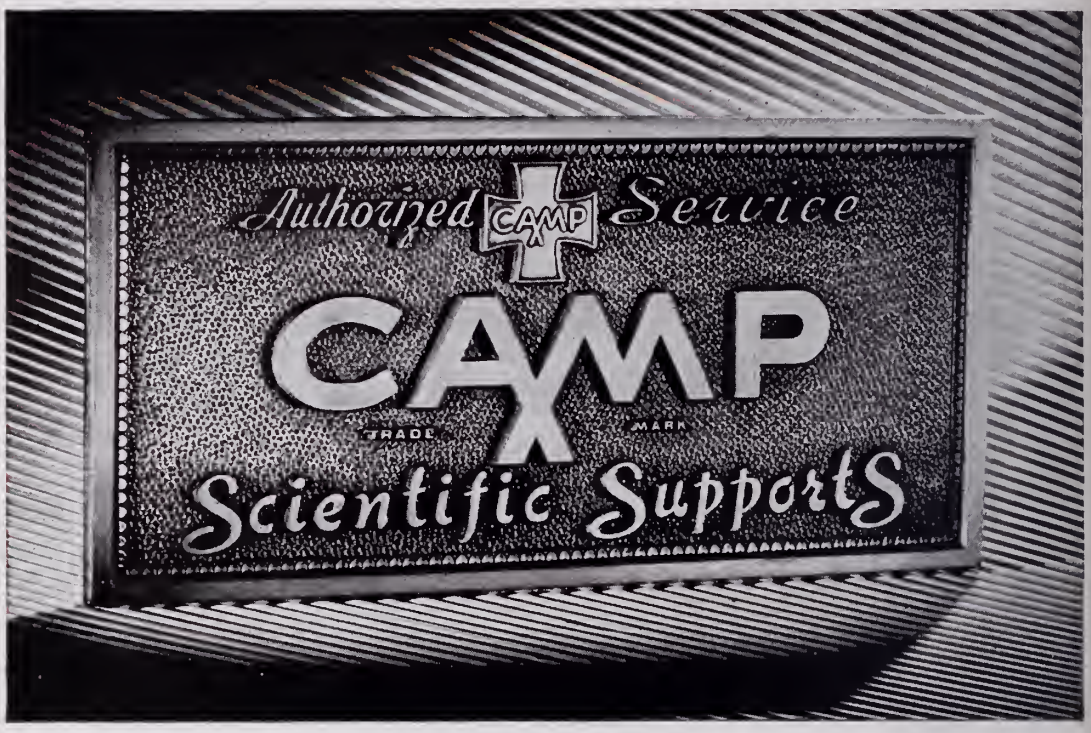

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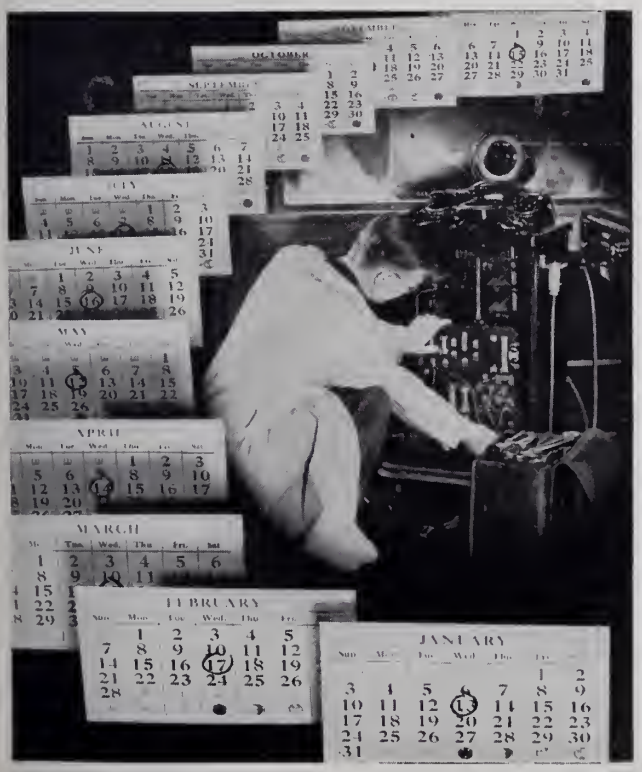

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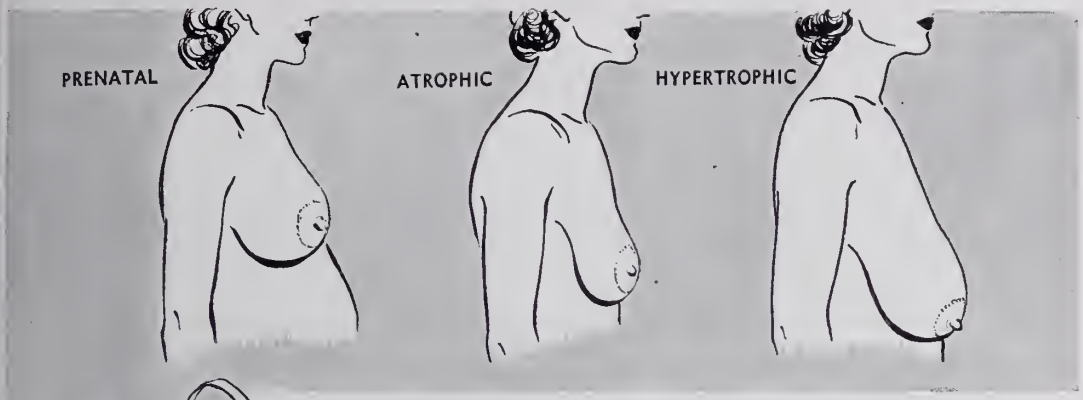

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*Laryngoscope, Feb. 1935, Vol. XLV, No. 2, 149-154
Laryngoscope, Jan. 1937, Vol. XLVII, No. 1, 58-60
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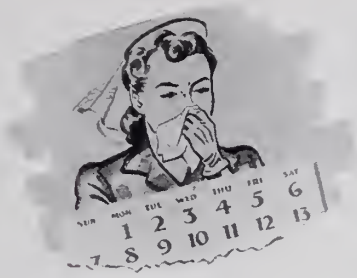

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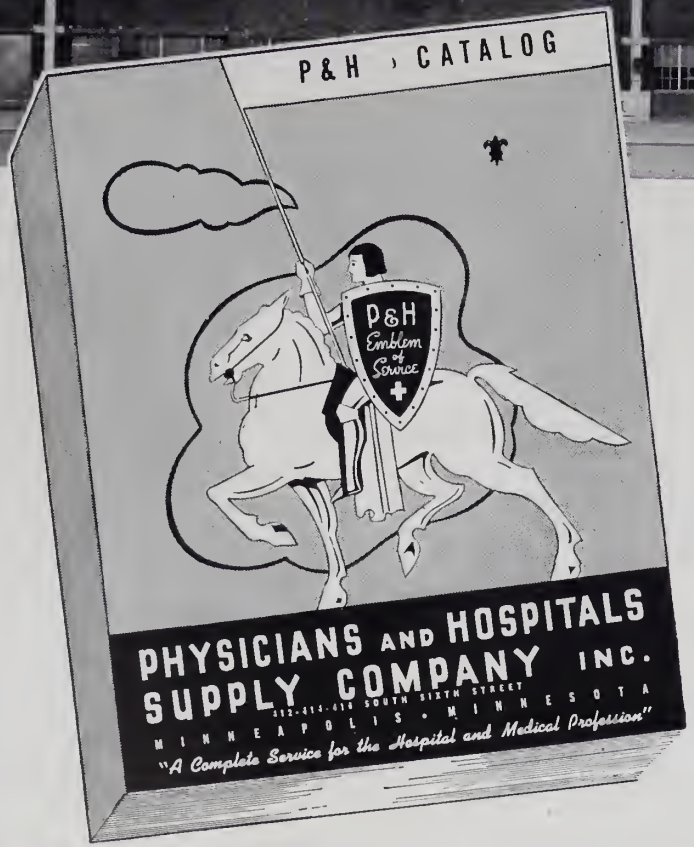

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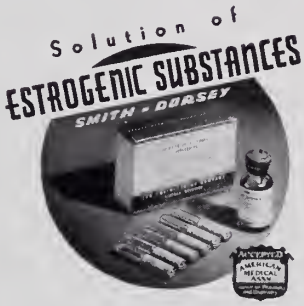

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Pathologic Physiology of Hemorrhage*

By FREDERICK W. MADISON, M. D.**
Milwaukee

HE blood is a highly complex fluid which is of such vital importance in the mainte-ance of the normal functions of the tissues f the body that relatively slight quantita-ıve or qualitative variations in its compo-ent parts are promptly reflected in disturb-nces in the physiologic processes of those ıssues. It is contained within the vascular ystem, which consists of two distinct parts: he arteries, arterioles, veins, and venules, hich have the function of distributing and ollecting the blood; and the very extensive apillaries, in which all of the vital functions f the blood are carried out. It may be well o recall that these functions are roughly the elivery to the tissues of oxygen from the ıngs and nutriment and water from the astrointestinal tract, the removal from the issues of carbon dioxide and other metabo-ites, the maintenance of normal body tem-erature, and the transportation of regula-ory substances of hormonal type and of va-ious protective substances.

The Vascular System

The vascular system is essentially a closed ystem, so constructed that alterations in the olume and composition of the blood never ccur under normal circumstances in the dis-ributing portion and that the alterations hich occur incident to the performance of he physiologic functions in the capillaries ıre carefully compensated for in every de-ail. The capillary endothelium is normally eadily permeable in either direction to wa-er, crystalloids, and gases in solution, but ıot to colloids or blood cells. In the normal state, the amount of fluid and essential substances which passes through the capillary endothelium is determined and regulated by the hydrostatic and osmotic pressures in the capillaries and in the tissue spaces surrounding them, subject to variable modification of endothelial permeability by factors such as normal tissue metabolites of the H-substance type or vasomotor regulation. Certain abnormal states, however, such as anoxia, inflammation, and antigen-antibody reactions, are capable of changing the capillary endothelium sufficiently to greatly alter its permeability and, hence, to disturb this compensatory mechanism. But, in the absence of such gross disturbances of permeability, reduction of the hydrostatic pressure within the capillaries, such as occurs with loss of blood, will result in prompt passage of fluid from the tissue spaces to the vascular system in sufficient quantity to replace the loss if it has not been too great.

The cellular elements of the blood are produced by the bone marrow in response to various stimuli and probably under regulatory control by the spleen, which also serves as a reservoir for a reserve supply of cells. Loss of these elements within reasonable limits is readily replaced by utilization of this reserve supply and by increased activity on the part of the bone marrow.

Factors Influencing Extent of Hemorrhage

Hemorrhage is the term which is used to designate loss of whole blood and includes, therefore, both loss of cells and loss of plasma. The functional changes that occur as a result of such loss are necessarily complex and, from a clinical standpoint, present a wide range of manifestations that are dedependent on many factors, such as the site and mechanism of loss, the speed of loss, the effectiveness of hemostasis, which in turn

* Presented before the One Hundred First Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1942.

** From the Department of Medicine, Marquette University School of Medicine, Milwaukee.

determines the total amount of loss, and the compensatory capabilities of the capillaries, bone marrow, and spleen.

It has long been recognized that the blood itself possesses a normal hemostatic mechanism in its ability to coagulate when a defect occurs in the walls of the vascular system. Hayem[1] first demonstrated the presence of a mass composed of fibrin and blood platelets plugging an opening which had been experimentally produced in the jugular vein of a dog. The muscular walls of the distributing portion of the vascular system also possess the important ability to contract in the event of injury and thus to reduce the flow of blood until effective coagulation may occur.[2] Macfarlane[3] has recently shown that even the capillaries are normally capable of contracting under such circumstances.

Hemorrhage is always pathologic and can occur only as a result of a break in the wall of the vascular system. Such a defect is seen in clinical experience most frequently as the result of either trauma or ulceration. The extent of the hemorrhage will obviously depend on the size of the defect, the pressure within the portion of the vascular system in which the defect occurs and the effectiveness of the hemostatic factors, contractility, and coagulation. A relatively small opening in an artery may result in serious loss, whereas a similar opening in a vein with lower pressure may be of minor significance if hemostasis is effective. Likewise, if hemostasis is ineffective, as in the hemorrhagic diseases, serious loss may occur even from the capillaries.

The Effects of Hemorrhage

The amount of blood lost, together with the period over which the loss occurs, determines the systemic reaction to that loss. It is obvious that these factors may vary over an exceedingly wide range. In the instance of sudden massive sublethal hemorrhage, there is the well known dizziness, faintness progressing perhaps to syncope, perspiration, pallor due to peripheral constriction of the capillary bed, fall in blood pressure involving particularly the diastolic phase, increase in heart rate, and increase in rate and depth of respiration. These manifestations represent responses to relative anoxia of important viscera and to reduced blood volume with the prompt attempt to compensate by reduction of the size of the vascular bed and increase of the cardiac output. Certain of the elements of primary shock may also be present but are probably of nervous origin and are not to be confused with true shock. These symptoms in varying degree are characteristic of loss of perhaps 1,000 cc. to 1,500 cc. of whole blood over a relatively short period of time. Abrupt loss of probably 2,000 cc. or certainly 3,000 cc. results in death from anoxia.[4] Pathologic examination in such instances shows pallor and exsanguination as opposed to the visceral congestion found in secondary shock.[5] Immediately upon the occurrence of moderate degrees of blood loss the reserve supply of cells in the spleen and bone marrow are released into the circulating blood. This response, together with the reduced fluid volume, causes the peripheral blood count to remain at a normal level for a considerable period after the loss has occurred and, therefore, makes it of no value in determining the extent of the loss for at least twenty-four to forty-eight hours. Soon after the hemorrhage, the reduced hydrostatic pressure within the vascular system makes possible the flow of water from the tissue spaces in sufficient quantity to replace the lost fluid in whole or part. It is of importance that in hemorrhage the permeability of the capillary endothelium for colloids is not altered unless anoxia becomes very severe. Thus, fluid which is withdrawn from the tissue spaces or is introduced from the outside by the intravenous or subcutaneous route is retained within the vascular system. However, if anoxia is severe, the permeability is altered sufficiently to permit the colloids to pass to the tissue spaces and, because of the alteration of osmotic pressure, fluids may no longer be retained.[5]

It seems obvious, therefore, that after severe hemorrhage, blood should be given by transfusion early enough to prevent the degree of anoxia that may lead to such alteration of permeability and that administration of fluids, to be effective, must also be done before such a state occurs. The objection that transfusions of blood raise

blood pressure and therefore encourage further bleeding, however valid it may be, must be weighed very carefully against the far greater danger of loss of capillary integrity. It is also obvious from a clinical standpoint that the blood pressure, particularly the diastolic level, and the heart rate are more reliable indices of the extent of the loss of blood volume and the degree of anoxia than is the peripheral blood count.

The Regeneration Period

When the blood loss is markedly reduced or stopped, the blood pressure stabilizes or tends to rise, and the pulse becomes slower and of better volume. The peripheral blood count may continue to fall because of exhaustion of the reserve supplies and the increased dilution of the blood by tissue fluids. However, if shock appears, the loss of colloids will reduce or reverse the flow of these fluids and will result in less dilution with a false stabilization or even relative increase of the blood cells. In the absence of such an event, the peripheral count is apt to reach a true level at the end of about forty-eight hours and from that point on may serve as a fairly accurate guide to the extent of the blood loss and the efficiency of the compensatory mechanism. At this stage there may be a considerable number of reticulocytes in the peripheral blood, reflecting the active regenerative efforts of the bone marrow. In order to keep tissue anoxia at as low a level as possible, it is practical, and probably good clinical practice, to attempt to maintain the peripheral red blood at or above 3,500,000 per cm. by the transfusion of blood. Regeneration of red blood cells occurs at the rate of about 150,000 cells per day, depending somewhat on the severity of the blood loss. Formation of hemoglobin is apt to fall a little behind the manufacture of red cells, either because the iron reserve may have been depleted by previous loss or because the reserve is not readily made available in sufficient quantity. The administration of moderate amounts of iron during the regeneration period may, therefore, have very real value. It is a safe and conservative clinical rule to allow thirty days for complete recovery from severe hemorrhage. If it has not occurred within that period of time, it is probable either that blood loss is continuing or that there was a previously existing deficiency of substances necessary for the maturation of the blood cells.

Hemorrhage of less than 1,000 cc. may produce few or no symptoms other than those of primary shock and therefore is not apt to produce significant clinical manifestations. Under such circumstances, the compensatory mechanisms, if functioning adequately, are usually capable of restoring the blood to its normal functional state in a relatively short time. However, small recurrent hemorrhages may deplete the iron reserve and reduce the efficiency of the bone marrow mechanism to the extent of causing an intermittent or more or less constant hypochromic anemia. Hypochromia is so characteristically the result of small, continued, or recurrent hemorrhage that its presence should always require a careful and persistent search for the site of such hemorrhage. Therapy must include not only the elimination of that site but must also replace the iron which has been lost.

Summary

1. The vascular system is constructed in such a manner that loss of whole blood does not occur under normal circumstances.

2. Hemorrhage, or loss of whole blood, occurs only as a result of a defect in the walls of the vascular system, but the extent of the loss depends upon the pressure in the portion in which the defect occurs, the size of the defect, and the adequacy of the two factors in the hemostatic mechanism, vascular contractility and coagulability.

3. The effects of hemorrhage are principally dependent on the loss of fluid volume and the visceral anoxia resulting from reduction of oxygen-carrying capacity and are directly proportional to the extent and speed of the blood loss. Recurrent or persistent small hemorrhage may result also in serious depletion of iron reserves.

4. Proper therapeutic management must be based upon elimination of the site of hemorrhage, avoidance of severe tissue anoxia, replacement of fluid volume, and the

introduction of cell maturation factors if they are needed.

BIBLIOGRAPHY

1. Hayem, G.: Acad. Sci. Paris 95:18, 1882.
2. Best, Charles H., and Taylor, Norman B.: The Physiological Basis of Medical Practice, Baltimore, The Williams and Wilkins Company, 1939, p. 36.
3. Macfarlane, R. G.: Critical Review: The Mechanism of Haemostasis, Quart. J. Med. 34:1 (Jan.) 1941.
4. Whitby, Lionel E. H., and Britton, C. J. C.: Disorders of the Blood, Philadelphia, P. Blakiston's Son and Co. Inc., 1939, p. 143.
5. Moon, Virgil H.: Shock and Related Capillary Phenomena, New York, Oxford University Press, 1938, p. 172.

Treatment of Shock*

By CONDE F. CONROY, M. D.**

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THE term "shock" has been used for 150 years to describe a clinical picture which is easily recognizable when fully developed but often overlooked in its incipient stage. The attention of the physician treating an injured person is naturally directed to the conditions which are most obvious, such as bleeding lacerations, fractures, and burns. In his zeal to treat the obvious, he overlooks slowly developing shock. As it is usually the shock which kills the person, its onset should be watched for, and energetic measures of treatment should be instituted as soon as it is recognized. Better still, the prevention of shock should be attempted, as shock may become an irreversible condition when once well developed.

A search for a single causative factor that produces shock has so far been unsuccessful. The probable reasons for this are that the causal factors vary and that the responses to injury of this complicated human body of ours also vary greatly. We are fairly certain that shock is a type of peripheral circulatory failure. A constant and early recognizable finding is oligemia, that is, a diminution in the effective circulating volume of blood. This may be due to the decrease in blood volume, an increase in size of the vascular bed, or both. In cases of hemorrhage, the cause of the decrease in blood volume is obvious, but in cases of shock in which hemorrhage is not present, the reasons are not well understood.

Primary and Secondary Shock

The physician is seldom called upon to treat primary shock or syncope. This condition, which is due to a reflex vasodilatation, is transient in nature, and recovery usually has taken place before the physician reaches the patient. In some rare instances, primary shock may continue and pass into the more important secondary shock.

Secondary shock or peripheral circulatory failure, as Blalock believes it should be called, is a lethal condition which should be watched for, recognized, and promptly treated. Given a patient who has been injured and presents an anxious look, a cold clammy skin, a weak thready pulse, and a lowered blood pressure, what can the physician do for him?

Treatment of Shock

The removal of the cause of shock should be done wherever possible. Hemorrhage should be stopped, fractures immobilized in good position, and pain relieved by adequate doses of morphine. By this I do not mean that all lacerations should be immediately cleansed and sutured, or that perfect anatomic reposition of fractured bones is necessary at this time. Large vessels should be clamped or ligated, and fractures should be aligned and put in some form of comfortable fixation. Shock should then be energetically treated and the finer points in treatment be carried out after the patient has recovered from shock.

The three cardinal points in the treatment of shock are relief of pain, rest, and warmth. These simple procedures usually can be carried out any place and especially in well equipped hospitals, but they are often overlooked or neglected in favor of some new and dramatic form of therapy.

Morphine in adequate doses should be given as soon as possible to relieve pain, but

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excessive doses depress the medullary centers and produce an anoxia.

Rest and warmth go together. The patient should be put to bed if possible, wet clothing should be removed, and external heat should be applied. Hot water bottles or glass bottles filled with hot water should be placed around the patient and outside the blankets, care always being taken to prevent burning the patient. An ideal method which is being used at the Milwaukee County Hospital is the use of a hot air bed warmer. This apparatus is nothing but a glorified hot air hair dryer mounted on a cart which is wheeled up to the patient's bed. The spout, a flexible rubber hose, is introduced beneath the blankets, and in twenty seconds the bed is warm and comfortable. There is no danger of burning the patient. Too much cannot be said in favor of this simple piece of apparatus. All well equipped hospitals should have one. External heat should never be so intense as to produce profuse perspiration, as this will lead to further dehydration of a patient already low in fluid volume.

Use of Drugs

Physicians are always searching for a single drug which, in one injection, will right a pathologic process. This has been true in shock, and a long list of drugs such as epinephrine, ephedrine, benzedrine, strychnine, coramine, and camphor, to mention only a few, have been used in the treatment of shock. The most popular of these is epinephrine. The consensus of opinion is that the benefit derived by their use is far outweighed by the sum total of their ill effects. Remembering that decreased blood flow through the capillaries is an early symptom and that vasoconstrictors still further diminish the blood flow, one will not readily use them even if they do raise the blood pressure somewhat.

Caffeine has frequently been used. There is some evidence that it does increase the blood flow and therefore decreases the anoxia in the capillary and venular systems.

A drug which holds some promise is an extract of the cortex of the adrenal gland (eschatin). It has been shown by Roads, Wolff, and Lee that if this substance is added to a plasma infusion, it tends to cause a retention of the plasma within the circulation by decreasing the permeability of the capillaries. If given alone, this hormone is ineffective. Considerable reserve should be exercised in accepting its use until a much larger series of well controlled cases can be presented.

Administration of Fluids

The replenishment of blood volume has long been recognized as the paramount objective in treating shock. Usually the ideal way to administer fluids is by mouth, but in cases of shock the absorption is slow, and nausea and vomiting may prevent retention; therefore, some other route must be chosen. Because of the hypotension, subcutaneous and intramuscular infusions are not readily absorbed, and, consequently, the intravenous route remains the best way for increasing the blood volume.

Until just recently, the crystalloids, such as 5 per cent glucose solution or normal saline solutions, were our mainstays. They were readily available, were cheap, could be stored, would remain sterile, and were not toxic. Now there has been accumulated a great deal of evidence that they are more or less ineffective, the reason being that if there is a reduction in blood volume by the loss of plasma through increased permeability of the capillaries, crystalloids given intravenously dilute the remaining plasma and allow it to pass through the damaged capillary walls more easily. These crystalloids are of more value in the prevention of shock than in the treatment of a well established case. They do restore the blood pressure, but in a true oligemia with increased capillary permeability, they are not desirable.

Colloidal solutions used in the treatment of shock, such as gum acacia solutions, have fallen into disrepute because of the number of sudden deaths which followed their use.

Casein digested by papain contains the essential amino acids, and, in a 5 per cent solution, it is readily tolerated intravenously. Its chief value seems to be in the restoration of plasma proteins. It is slow in action and of doubtful value in the treatment of shock.

In the last few years, blood blanks have been established in most hospitals and have made readily available our two best colloidal solutions, whole blood and plasma. The main

indication for whole blood in the treatment of shock is hemorrhage with severe blood loss. When plasma loss has been great, as in burns, and one is dealing with a true hemoconcentration, the giving of whole blood may be detrimental. In other words, when both whole blood and plasma are available, replace that which has been lost.

Plasma has often been called a blood substitute. This is not true, but its use in hemorrhage shock is justified until whole blood can be typed. Some workers have found that pooled plasma can be given without cross typing and that a single flask of unpooled plasma, 250 cc., may also be given untyped. However, when frequent administration of plasma is necessary, it is believed that unpooled plasma should be cross typed before use. The availability of citrated plasma, fresh, frozen or dried, has been the biggest development in the treatment of shock in recent years. If frozen or dried plasma can be made cheaply, this will solve the problem of a readily available supply in the small institution that does not have a blood bank.

Administration of Oxygen

In cases of shock, the blood flow through the capillaries is slowed, and the oxygen carried by the red cells is given off to the tissues in greater amounts than normally. Therefore, the venous blood contains only 20 per cent oxygen instead of the normal 60 per cent. Because of this fact, it has been suggested that the patient in shock breathe 100 per cent oxygen instead of the 20 per cent oxygen in atmospheric air, and thereby increase the total oxygen carried by the blood stream. In actual practice, the blood will pick up only 2.2 cc. more oxygen per 100 cc. of blood when pure oxygen is being inhaled. While this is a very small amount, the capillaries will contain from 10 to 15 per cent more oxygen than while the patient is breathing atmospheric air. Wood, Mason, and Blalock regard this as useful in the treatment of shock. Oxygen may be administered by the use of tents or masks. Continued use of pure oxygen is not without danger, and its administration should be stopped at intervals if the patient's condition permits.

Summary

1. Shock is easily recognized when fully developed but often overlooked in its incipient stages when treatment would be more effective. Prevention should be our aim whenever possible.

2. Removal of the cause of shock by proper first-aid measures is our first aim.

3. Rest, relief of pain, and warmth must be attained as soon as possible.

4. Drugs are of little avail. Ephedrine is to be used very cautiously. Caffeine seems to produce some improvement. Adrenal cortex hormone is probably a valuable adjunct to transfusions of plasma.

5. Crystalloid infusions are of value in dehydration and in the prevention of shock but are detrimental in the treatment of this condition.

6. The colloidal solutions, such as gum acacia, ascitic fluids and amino acid solutions, should best be avoided.

7. Whole blood is the fluid par excellence in cases where all elements of the blood have been lost, as in hemorrhage.

8. Plasma is the fluid par excellence in cases of hemoconcentration.

9. Oxygen is of some value in the treatment of well established shock.

BIBLIOGRAPHY

1. Andries, W. D.: Present Concepts of Origin and Treatment of Traumatic Shock, Surg., Gynec. & Obst. 75:161, 1942.
2. Atchley, D. W.: Blood Changes in Intestinal Obstruction, New York State J. Med. 33:1191 (Oct 15) 1933.
3. Bartlett, Willard: An Experimental Study of the Arteries in Shock, J. Exper. Med. 15:415 (April 1) 1912.
4. Blalock, A.: Principles of Surgical Care, St. Louis C. V. Mosby Company, 1940.
5. Blalock, A.; Wilson, H.; Weinstein, B. M., and Beard, J. W.: Loss of Protein from the Blood Stream, Arch. Surg. 26:330 (Feb.) 1933.
6. DeBakey, M., and Honold, E.: Blood Transfusion Methods and Technic, Internat. M. Digest 34:4: (Jan.) 1939.
7. Erlanger, J.; Gesell, R., and Gasser, H. S.: Studies in Secondary Traumatic Shock, Am. J. Physiol 49:90 (June) 1919.
8. Fantus, Bernard, Editor: The Therapy of the Cook County Hospital: Blood Preservation, J. A. M. A. 109:128 (July 10) 1937.
9. Gatch, W. D., and Little, W. D.: Amount of Blood Lost During Some of the More Common Operations, J. A. M. A. 83:1075 (Oct. 4) 1924.
10. Harkins, H. N., and Harmon, P. H.: Plasma Exudation, Ann. Surg. 106: 1070 (Dec.) 1937.
11. Ravdin, Isidor S.: Some Recent Advances in Surgical Therapeusis, Ann. Surg. 109:321 (March 1939.

Shock and Hemorrhage*

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N DISCUSSING the subject of shock and hemorrhage, I should like to present the icture without the entanglements of lengthy efinition, argument in regard to etiology, nd the endlessness of confusing terminolgy. Without shame, I have borrowed varias opinions of many excellent experimentalts and from the experiences of clinicians nd surgeons who have served on the field of attle in World War I, the Spanish Civil Var, and the present World War II. These inicians and surgeons, I believe, see this icture more clearly from a practical point f view than the pure research worker. From certain amount of chaos, I should like to resent, as I see it, a clearer conception f the relationship between shock and emorrhage.

Cowell states that the term "shock" should ot be used without qualification. In civilian urgery we should recognize it as "surgical" r "traumatic shock." In military surgery e believes the term "wound shock" is more ccurate and descriptive. This avoids confuion with "shellshock," or shock resulting rom a transitory psychic disturbance. 'herefore, from a military standpoint, vound shock is secondary shock.

The nervous phenomenon we see in prinary or early shock plays but a small part in vound or secondary shock. However, it is mportant that we recognize all shock as a ailure of the circulation. As a result of a vound or injury, the vitality of the body is owered, and circulatory failure may rapidly levelop. Blalock states, "Shock is a condition of peripheral circulatory failure brought on by a discrepancy between the volume of circulating blood and the size of the vascular system, and leads to a deficient blood supply o the tissues of the body."

Those who have occasion to deal with miliary casualties should have a clear conception of the clinical picture of shock. Unfortunately, there is no method for determining the efficiency of the circulation in early or incipient shock. It is unusual for the blood pressure to fall before marked changes have occurred in the circulation; therefore, the reading of the manometer is not an all in all index. A patient may have cold extremities as a result of arterial vasoconstriction. This vasoconstriction may be secondary to a reduction in the blood volume, and we would find a low blood pressure reading. Such a case presents a grave prognosis unless the blood volume can be elevated and sustained. On the other hand, a patient may have a low blood pressure and warm extremities with no signficant reduction in blood volume.

Shock and Hemorrhage Similar in Syndromes

For a long time it was believed that the syndromes of hemorrhage and shock were the same. There are several factors in the syndrome of shock that may occur after hemorrhage, such as: (1) a strong, rapid pulse from myocardial stimulation; (2) peripheral vasoconstriction which is shown by a reduced volume flow, giving pallor and loss of tissue fullness; (3) an increase in the blood sugar; (4) dilated pupils; (5) sweating; (6) a low basal metabolism; (7) an increase in the alkaline reserve; (8) a decrease in the serum protein; (9) an increase in the respiratory rate; and (10) a low arterial pressure, especially in the later stages when death due to an inadequate circulation, finally ensues. Both shock and hemorrhage evoke compensatory reactions. Moon and his associates have shown these changes in dogs, and their results were comparable to those observed by workers in the field of military medicine.

Shock and Hemorrhage Differ in Clinical Features

As stated above, shock and hemorrhage are similar, but they differ in the following important clinical features: (1) fluid bal-

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ance, which is markedly disturbed in shock but remains undisturbed in hemorrhage; (2) vomiting and dysentery, which usually accompany severe shock but are rarely seen as a direct result of hemorrhage; (3) blood volume, which is increased in shock and decreased in hemorrhage; that is, there is a hemoconcentration in the former; (4) a decrease in serum protein and a rise in the blood sugar, both of which are more marked in hemorrhage than in shock; (5) the nonprotein nitrogen, which is increased in shock but decreased in hemorrhage. The findings at necropsy show a characteristic edema of the soft tissues in patients who have died from shock, which accounts for the increase in the weight of the organs. The tissues of those who die from hemorrhage are ischemic. While it is true that hemorrhage can produce shock, such a condition should be called hemorrhagic shock.

Stead points out that there are two types of circulatory failure. The first is due to congested heart failure, which is a result of the inability of the heart to pump an adequate blood supply to the tissues because of disease or some mechanical defect. Such failure is recognized by dyspnea, edema, a prolonged circulatory time, and an increase in the venous pressure and blood volume. In such a condition there is a congestion in the pulmonic circuit which is absent in the systemic system. In the second type, shock or circulatory collapse, there is a failure of the venous return to the heart. This results in a marked decrease in the cardiac output, which quickly causes tissue anoxemia. Such circulatory collapse causes pallor, cold extremities, sweating, a weak and thready pulse, and an unbalanced consciousness. The alert facies usually characteristic of the hemorrhagic patient is in direct contrast to the dull and apathetic expression of the patient in shock.

As hemorrhage and shock may be present at the same time in patients suffering injury from military action, the physician must be on the alert to recognize this possibility. In treating soldiers, the surgeon is less likely to see a decreased heart output due to cardiac disease than in treating civilians.

While any discussion on shock is likely to become outdated because such rapid strides are being made in surgery, anesthesiology, chemotherapy, and biochemistry, it might be well to pause for a minute to review what is generally known or accepted. Is primary shock caused by some hitherto unknown toxic substance, is it due to a disturbed function of the nervous system, or is it caused by local loss of blood or fluid?

The Toxemia Theory

Supporting the theory of toxemia is the condition of shock produced by the introduction into the system of snake venom or other toxic substances, such as material obtained from dead or dying tissue. Although a patient is given adequate first aid after having had a leg blasted off on the field of battle, and although he is transported to a field hospital in good condition with no evidence of shock present, gangrene developing in the stump has been given as a causative agent in the severe shock which usually follows. In spite of such evidence, toxemia in wound shock is not usually considered as a causative factor.

The Neurogenic Theory

Supporting the neurogenic theory is the fact that vasoconstriction occurs in shock, as it does in hemorrhage, as a compensatory reaction. Such factors as fear, anger, pain, cold, and mental stress will also produce vasoconstriction. Vasoconstriction in itself probably does not produce fatal results; but because of it, there is a diminution of the blood flow, and tissue anoxia results. A patient may have hypertension with a severe vasoconstriction with no evidence of shock. Individuals may suffer severe shock from a bomb blast with no sign of external injury. In spite of the fact that the most outstanding lesion from a blast is bilateral pulmonary hemorrhage, Hatfield thinks that such a blast produces death by interfering with some vital tissue or nerve center in which, from the the extreme rapidity of action, structural changes are unlikely to be found. The neurogenic theory, therefore, does not explain very satisfactorily the cause of secondary or wound shock.

Local Loss of Blood and Fluid

The most generally accepted theory for the cause of shock is the local loss of blood and

fluid. This theory, proved by many experiments, is rarely found under actual military conditions. For instance, it has been shown that animals whose extremities had previously been bound with tape and given a crushing injury suffered shock, although they did not lose any blood or fluid. Blalock pointed out that such animals were anesthetized, which in itself would account for the loss of life in certain cases. He states that such experiments would only be significant in individuals who had been pinned under some object, as debris from an air raid. Severe trauma, which is usually accompanied by the loss of whole blood, causes a greater proportional loss of plasma than erythrocytes. Persons having minor injuries, especially, suffer a loss of plasma. Burn cases are the most striking example. The protein which accumulates at the site of the burn is practically identical with that of the plasma of the blood vessels. Blalock found that in burn cases, of approximately twenty-four hours' duration, the loss of plasma in itself was sufficient to account for the reduction of blood pressure. While the loss of plasma does not necessarily produce death, its loss is one of the most important factors in the cause of shock resulting from burns.

British Observations of Wound Shock

Wound, or secondary, shock, as usually seen on the field of battle, is the condition which the British have had such an ample opportunity to observe. Mitchiner and Cowell have summed up the British experience in a treatise especially adapted for emergency medical service, feeling that a clear picture of the causation of wound shock was obtained by four factors: (1) pain, (2) loss of heat, (3) bleeding and (4) toxemia (bacterial or otherwise). It was found that the common variety of wound shock, that is, secondary shock, developed in several hours, and that if the four above-mentioned factors were properly combatted, shock would not occur. On the battlefield, the soldier is usually deficient in fluids, as his output is increased by sweating and his intake restricted by small water rations. The same conditions could result in civilian casualties, particularly during aid raids.

As pain may be a causative factor in the lowering of blood pressure, British surgeons believe that the afferent nerve impulses do not appear to produce shock unless they actually cause pain. It was found that in leg or arm amputations, even in very old people, such operations could be carried out with comparatively little shock if the great nerve or nerve plexus was not divided until the very last of the operation.

Loss of heat is a very important factor in producing shock. Wounded men who had but trivial wounds suffered shock while they were being transported back from the trenches without adequate covers or were unduly exposed to cold for a long period. These men often recovered as soon as they were made warm.

Patients in shock have an increased viscosity of the blood, a raised hematocrit index, and a greatly diminished blood volume. Blood taken from capillaries shows a high hemoglobin content and a raised red cell count; while venous blood taken at the same time from the same patient gives low readings.

Such capillary stasis in vital organs, such as the heart and brain, damages both the heart muscle action and the medullary vasomotor centers. The blood pressure sinks lower and lower, and death finally results. Only a reversal of this process can save life. Cannon states that if the systolic blood pressure stays at 80 mm. of mercury or lower for a period of more than four hours, recovery is hopeless. Failure of the circulation, with resulting loss of intracellular oxygenation, is so devastating that the finer cells are unable to recover. Toxic effects can also be produced by the concentration of the blood urea which accompanies shock.

Secondary or wound shock is most frequently seen in war casualties from external bleeding, bleeding into the pleural and peritoneal cavities, loss of blood and fluid into the tissue as a result of trauma, and the loss of plasma, as at the site of a burn. Here we see the picture of decreased blood volume, vasoconstriction, a decrease in the cardiac output, and, subsequently, a decline in the blood pressure. In such cases, the loss of blood and fluid is the most frequently initiating factor. However, dehydration from a

previous illness or that resulting from strenuous activity, psychogenic factors, hemorrhage, anesthesia, loss of plasma from exposed traumatized areas, infection, toxemia, and others all play their role in the complex picture of shock.

Blood Volume in Shock

Kieth observed that the blood volume in a series of cases in shock was reduced to 52 to 85 per cent of normal, and at the same time the plasma was reduced 62 to 90 per cent. He described three groups:

1. Compensative cases, with but slight symptoms, in which the blood pressure stayed above 110 mm., the blood volume never fell below 80 per cent of the normal, and the plasma was not reduced in proportion.

2. Partially compensative cases in which there were histories of small hemorrhages, and the patients were restless, cold, thirsty, and were vomiting. The pulse rate was 120 to 140, the blood pressure 70 mm., and the blood volume 65 to 75 per cent, with a slight dilution of the plasma.

3. Uncompensative cases in which the condition was very severe, and extreme restlessness, thirst and vomiting prevailed. The extremities were cold and the pulse impalpable. The blood pressure was 60 mm., or less, the cardiac rate up to 160, and the blood volume below 65 per cent.

He concurred with Cannon's statement: "That dictum uttered by the older generation of surgeons, that 'shock is hemorrhage and hemorrhage is shock,' is true."

Moon, on the other hand, states that although there are points of similarity between shock and hemorrhage which result from the fact that each evokes the same mechanism of compensation, he feels that the points of contrast between the two are so numerous that the assumed identity of those conditions is no longer tenable.

In closing, I wish to state that, regardless of theory, it is most important for all of us, who may have to deal with casualties resulting from enemy action, to recognize wound shock early, to prevent it when possible, and to have facilities ready for its immediate and adequate treatment.

PEN-LIGHT AND INSTRUMENT BATTERIES

Advice has been received from physicians in various areas in the state that it has been impossible for them to obtain batteries for their pen-light flashlights that are used in illuminating the throat and for use in connection with battery-lighted otoscopes, ophthalmoscopes and similar instruments.

If members of the Society encounter difficulty and find it impossible to obtain batteries locally and if they will advise the Society's office of the size number of the batteries used and the quantities essential to take care of current needs, we will, through priority arrangements, attempt to obtain these needed supplies at the prevailing retail rate. For example—three Number 2 Unit Cell (Ray-O-Vac) or two Number 7R Pen-Light Unit Cells (Ray-O-Vac).

The Treatment of Obstetric Hemorrhage*

By JOSEPH M. FREEMAN, M. D.
Wausau

IT IS customary to define obstetric hemorrhage as to the time of its occurrence during delivery, that is, ante partum, intra partum, or postpartum. The successful treatment involves, first of all, the correct diagnosis of the existing pathologic condition resulting in excessive bleeding.

The maximum blood loss in normal obstetric cases has been arbitrarily accepted as being about 600 cc. This varies, of course, with the size of the patient. Since hemorrhage in excess of this amount delays the return of the mother to her previous strength and increases the incidence of puerperal infection, it is important that we employ all possible means of keeping bleeding at a minimum. Prevention plays the all important role in attaining this goal. The routine administration of vitamin D in the last several days of pregnancy has been employed by many. As to its efficiency, I have no proof to offer.

In regard to the obstetric complications causing ante partum hemorrhage, premature separation of the placenta and placenta praevia are the most dramatic. Patients presenting these complications should be immediately hospitalized and provision made for emergency transfusion either from voluntary or paid donors or from a blood bank. The type of delivery is next decided upon. When a definite course of procedure is determined, one should adhere strictly to this decision. It should be borne in mind that the mother's condition is of primary importance and that the delivery is part of the preventive treatment of maternal hemorrhage.

Cesarian section is indicated in many of these cases but never when there has been intravaginal manipulation. Accouchment forcé is to be condemned. However, rupture of the membranes, tamponade, and use of an intraovular bag are procedures of definite value in aiding delivery by the natural route.

As stated before, prevention is of major importance in the treatment of intra partum and postpartum hemorrhage. Hurrying a delivery by the use of oxytocics or by operative procedure before the cervix is completely dilated and the pelvic soft parts are prepared for it can result only in cervical lacerations and tears of the vaginal vault and perineum.

Causes of Postpartum Hemorrhage

Curtis lists the causes of postpartum hemorrhage in their order of frequency as follows: atony of the uterus, lacerations of the birth canal, retention of placental tissue, rupture of a blood vessel, and inversion of the uterus.

Atony

Atony is a failure of the normal hemostatic contractions of the uterus. The mechanism of this function is a direct compression of the smaller vessels by the contraction of the surrounding muscle fibers and a compression and kinking of the larger vessels as the muscle layers contract and retract overlapping each other. Atony may follow overdistention and result in hemorrhage during or after delivery in cases of hydramnion or multiple pregnancy. Other contributing factors may be endocrine dysfunction, lack of normal nervous control, maternal malnutrition or an otherwise weakened state as in prolonged anesthesia. Improper conduct of the third stage may also result in atony, such as the atony which results when the fundus has been forcibly massaged and pushed down into the pelvis in attempts to express the placenta before its separation from the uterine wall. This procedure likewise tends to cause incomplete separation, and, while the main body of the placenta is delivered, fragments may be retained that add to the state of atony and consequently increase the amount of bleeding.

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Separation of the placenta from the uterine wall normally results from retroplacental hemorrhage and uterine contractions of variable number. As this retroplacental hematoma forms, it raises the fundus into the hypogastrium and forces the separated placenta down into the lower uterine segment, as indicated by descent of the cord. Referring to the work of Calkins, Pastore advises that the attendant devote his entire attention to these occurrences. He describes the fundus as discoid in shape immediately after the birth of the baby. As the retroplacental hematoma forms and separates the placenta, the fundus changes to a globular form and should remain firmly contracted. These changes are noted by palpation. When the changes are complete, an assistant should place one hand above the symphysis with fingers pushing beneath it, thus palpating the lower uterine segment. The other hand should gently massage the fundus and aid in expressing the placenta through the lower strait into the vagina. This maneuver also prevents pushing the uterus into the pelvis, in which position venous drainage through the uterine veins is obstructed and congestion of the venous sinuses and veins of the fundus is increased with resultant hemorrhage. It is emphatically urged that we aid the fundus in expressing the placenta only when it is in a contracted state. With the placenta in the vagina, its complete delivery is aided by light traction on the cord. The fundus should not be used as a piston to complete its delivery. Pastore maintains that the aforementioned should occur within a few minutes after delivery of the baby and that delay in terminating the third stage results in unnecessary blood loss in the retroplacental hematoma.

After the placenta has been delivered, it should be reconstructed to determine the absence of any fragments and the presence of a succenturiate placenta. This latter condition is determined when one finds a large vein leading from the main body of the placenta into the membranous veil and abruptly terminating as if broken off.

Manual delivery of the placenta is necessary when the normal mechanism for its delivery has failed or when placental fragments have been retained with a possibility of atony and hemorrhage. Here the strictest asepsis should be employed. One should use clean gloves and avoid pushing the cord and portions of the membranes that have been externally exposed back into the birth canal. Beginning from above and progressing downward, one should separate the retained or adherent placenta and placental fragments with lateral sweeps of the hand. This allows the fundus to contract on the descending hand and prevents perforation of the uterine wall by digging fingers. The external hand should palpate the fundus during this procedure.

Lacerations

Hemorrhage from lacerations is characterized by excessive bleeding during and immediately after delivery. It is usually bright red. Inspection determines its location. In regard to any such hemorrhage which is alarming in amount, Curtis has graphically described in his textbook the method of clamping the uterine vessels with a sponge forcep until bleeding vessels can be tied off, the placenta delivered, and the laceration repaired. Adequate exposure can be obtained by vaginal retraction and by using sponge forceps applied to the anterior and posterior lips of the cervix to deliver the cervix into the field by traction. Through and through catgut sutures are used in approximating the edges of the laceration and should not be too tightly tied.

Tears deep in the vaginal vault are not usually the cause of serious bleeding. When such tears are being repaired, no deep bites with the suturing needle should be made because of the danger of perforating the adjacent rectum. Authorities differ as to the time of repair of a perineal laceration. Some maintain that it is a good practice to make this repair while one is waiting for the placenta to separate. It is logical that no hard and fast routine can be followed. The condition contributing to the greatest amount of maternal blood loss should receive first attention.

Routine inspection for lacerations of the cervix and vagina in the normal spontaneous delivery with no abnormal bleeding is unnecessary.

Inversion of the Uterus

Hemorrhage from inversion of the uterus is not always severe. The greatest danger is infection. It most frequently results from pressure on the relaxed fundus combined with traction on the cord in attempts to deliver the placenta. Although undetectable, contributing factors may exist that aid in producing this condition. The proper conduct of the third stage in order to avoid such complication of delivery is of the greatest importance.

The value of oxytocic agents in the prevention and control of uterine bleeding is well established. The time of administration varies in different clinics. Some physicians give pituitrin immediately after delivery of the presenting part. Others believe that this disturbs the normal separation of the placenta and leads to the retention of the placenta or fragments of it. The routine administration of one of the alkaloids of ergot either orally or intramuscularly after the termination of the third stage is good preventive practice. In the treatment of uterine atony, the oxytocics play a most important role. Ergonovine may be given intravenously. Pituitrin may be injected into the uterine musculature after exposure of the anterior surface of the lower uterine segment by traction on the anterior lip of the cervix and elevation of the anterior wall of the vagina. Hoyt describes the transabdominal route which is particularly applicable in patients with a thin abdominal wall.

Packing of the Uterus

If packing of the uterus and the birth canal is necessary in the control of obstetric hemorrhage, it should be resorted to early. The likelihood of puerperal infection's developing as a result of blood loss is greater than the possibility of infection introduced by packing, if the latter is carried out with proper technic. Packing performs two functions: 1. It aids in the control of hemorrhage by direct compression of the bleeding area. 2. It lifts the fundus out of the pelvis and thus affords adequate drainage and prevents venous engorgement.

The Holmes packer adds greatly to the ease with which this can be carried out and, if properly used, makes it strictly an aseptic procedure. The tube is passed through the cervix into the fundal cavity, and the pronged packer of shorter length than the tube pushes a gauze strip, previously sterilized in a glass container, into the uterus. As the cavity is filled, the tube is gradually pushed out. The packing should be removed in twenty-four hours. If hemorrhage recurs upon its removal, the uterus should be repacked.

The general measures for the treatment of obstetric hemorrhage are the same as in any hemorrhage case. Morphine should be given to allay restlessness. The patient should be placed in the Trendelenberg position, which not only improves circulation to the cardiorespiratory center in the brain stem but also keeps the fundus up out of the pelvis. The patient should be kept warm enough to maintain body temperature but not to a point which will produce dilation of the peripheral circulatory channels. In order to lessen the circulatory load and aid in oxygenation of cardiorespiratory centers, oxygen should be administered. In order to restore blood volume and combat anemia, one should give a transfusion early and repeat it as necessary. If blood is used from more than one donor, their bloods should be cross-matched with each other as well as with the recipient's to avoid transfusion reactions. In the event that blood is not immediately available, plasma and serum are the best substitutes to be used until blood can be procured. These may be supplemented by the intravenous infusion of normal saline and glucose solution. Used alone, the crystalloid solutions are entirely inadequate, and they may do harm by washing the protein elements of the blood out of circulation. During the stage of convalescence, an adequate diet is necessary supplemented by vitamin and iron therapy.

In conclusion, I quote from a personal communication from Dr. William C. Keettel of the State of Wisconsin Board of Health: "The classification of maternal deaths from 1930–1941, . . . shows a marked reduction in deaths due to sepsis and toxemia, but shows the hemorrhage deaths, while they have decreased, certainly have

not decreased in proportion to the other two. In fact, . . . in 1941, hemorrhage for the first time was a major cause of maternal deaths in Wisconsin.

"Sixty-eight questionnaires were sent out to doctors who had a death associated with obstetric hemorrhage. Only thirty-three were returned. From these thirty-three questionnaires, the following information was compiled:

"Thirty of the patients were in severe shock. On three there was no data. As far as treatment was concerned, twenty-four of the patients received intravenous saline or glucose, thirteen received a blood transfusion, five were given gum acacia solution intravenously, seven received morphine, twenty received external heat and ten were given some cardiac stimulant. Of the thirteen cases receiving blood transfusions, one received a transfusion within one hour after hemorrhage, six within one to two hours and six after two hours. Eight doctors mentioned voluntarily in the questionnaires that plasma or more prompt transfusion perhaps would have been a life saving measure."

BIBLIOGRAPHY

1. Harris, J. W.: Postpartum Hemorrhage—Causes, Prevention, and Treatment, Lecture Presented at Ninth Councilor District Meeting of the State Medical Society of Wisconsin, May 7, 1942.
2. Keettel, W. C.: Personal communication to the author.
3. Curtis, A. H., Editor: Obstetrics and Gynecology, Philadelphia, W. B. Saunders Co., 1933.
4. Hayes, W. I.: Treatment of Retained Placenta and Post Partum Haemorrhage, M. J. Australia 1,1935:472 (April 13) 1935.
5. Kottmeier, H. L.: Wochenschrift 68:1211, 1938.
6. Polak, J. O.: Accidental Hemorrhage—Ablatio Placentae, Am. J. Obst. & Gynec. 21:218 (Feb.) 1931.
7. Urner, J. A.: Postpartum Hemorrhage, Minnesota Med. 19:234 (April) 1936.
8. Hoyt, D. F.: Transabdominal Intra-uterine Injection, J. Michigan M. Soc. 40:217 (March) 1941.
9. De Puy, C. A.: Intra- and Postpartum Hemorrhage, California & West. Med. 47:233 (Oct.) 1937.
10. Picto, Harrison: Postpartum Hemorrhage, Virginia M. Monthly 68:154 (March) 1941.
11. Holmes, R. W.: The Hemorrhages of Late Pregnancy and Labor: Placenta Previa and Ablatio Placentae, Am. J. Surg. 48:61 (April) 1940.
12. Pastore, J. B.: Postpartum Hemorrhage, Am. J. Surg. 35:417 (Feb.) 1937.

The Treatment of Traumatic Hemorrhage*

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ACUTE hemorrhage, the most urgent of all medical problems, is one of the outstanding causes of the shock syndrome. It is almost impossible to mention either hemorrhage or shock without mentioning the other.

Treatment should start with prevention, and we should use all the varieties of prevention available. The exercise of caution and good judgment by the individual, the use of guards and protective machinery, and all of the safety programs and devices belong in this category. Injuries and accidents will occur, however, and the problem of acute blood loss will present itself in many ways.

We have heard of the physiology and mechanisms of hemorrhage and its frequently inseparable partner, shock. Our problem is to stop the hemorrhage, prevent the occurrence of or arrest the progress of shock, and promote healing so that the patient may recover.

First-Aid Measures

At the present time, great stress is being placed on war injuries and on civilian casualties associated with the war. The principles of first aid as they are now being taught certainly provide the first line of defense against acute hemorrhage under circumstances which permit the use of only the simplest and most immediate measures. The position of the patient lying down or with his head lowered helps maintain the vital blood supply to the brain. Direct pressure over the bleeding area can be made manually or maintained by a dressing and will suffice in most cases of capillary, venous, or even arterial hemorrhages. Accessible wounds should have the simplest kind of antiseptic

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and dressing care in situations which permit only minimum first-aid measures. The use of the six main pressure points, which are on the temporal, facial, carotid, subclavian, brachial, and femoral arteries, may be life-saving measures if direct pressure fails. In severe bleeding of the extremities, the tourniquet, too, may be used and often is the only effective means of success.

At the dressing station or at the hospital, where sterile surgical technic is possible, the ligation of bleeding points and thorough cleansing of the wound with abundant plain soap and sterile water followed by copious sterile saline washes should be gently, but thoroughly, carried out. Débridement of devitalized and potentially infected tissue and, if possible, removal of foreign bodies should be done. Wound edges can be freshened and local and general sulfonamides employed, thus often permitting immediate closure of the wound. Such a program arrests immediate hemorrhage and forestalls late hemorrhage, in addition to promoting immediate healing of the wound.

It is strictly true that a blood transfusion will cure acute blood loss if administered promptly enough. We know that circulatory collapse will occur if 15 to 20 per cent of the normal blood volume is rapidly removed from circulation. Prompt replacement of this loss is our problem.

Replacement by Whole Blood

Blood is the ultimate and ideal agent for replacing that which has been lost, but it has its disadvantages. Valuable time is lost while donors are being obtained and bled, and some patients may die because of the irreversible changes which occur during this interval. Blalock and many others have stressed this point. Moreover, it is a common experience that a patient whose blood pressure remains below the critical level of 60 mm. of mercury for a period of approximately four to six hours has, in the vast majority of cases, passed into that irreversible state of shock from which no amount of blood replacement can bring about recovery. Therefore, the time element alone in the treatment of hemorrhage is extremely vital. Fresh whole blood may be obtained from donors among relatives and friends, from professional donors, or from blood banks. When relatives are used as donors, blood matching requires time; the employment of professional donors requires time and is expensive; blood banks are also expensive and necessitate very close laboratory supervision.

Stored blood, if quite fresh, is nearly as efficacious as whole blood.

Replacement by Blood Substitutes

There are a number of blood substitutes, which include plasma, serum albumen, serum, hemoglobin Ringer's solution, gum saline or acacia solutions, red blood cells suspended in crystalloid solutions, and isotonic solutions such as saline or glucose. They are of therapeutic value in this order.

Plasma is the liquid material obtained by centrifuging whole blood to which an anticoagulant has been added. It may be used in liquid form as "wet plasma" or with the fluid removed as "dry plasma." There are several practical advantages in the use of plasma in traumatic hemorrhage and casualty surgery:

1. Because there is no need to group his blood, the patient can receive treatment in five minutes.
2. Plasma can be kept several months in its liquid form and almost indefinitely in its dry state.
3. There is no need for elaborate refrigerator storage.
4. Although the loss of plasma in severe burns is not truly hemorrhage, it is, nevertheless, a vascular system loss of fluid. In the treatment of severe burns, plasma is superior to and even more efficacious than whole blood.

When acute hemorrhage occurs, there is a spontaneous effort made to maintain blood pressure and adequate circulation by vasoconstriction. Within the first two hours there is a well recognized addition of fluid from the tissues to the blood stream, with a fall in plasma protein. It has been shown by British investigators that red blood cells increase 30 to 50 percent in size by osmosis from this low protein plasma. Thus, often as many as 20 per cent of the circulating

red blood cells get sidetracked in the capillaries, particularly those capillaries in the muscles. The administration of plasma then promptly replaces the circulating plasma to a normal level and also replaces blood volume, which in turn protects the blood flow to vital centers. This increased blood plasma volume permits the sidetracked 20 per cent of red blood cells to resume circulation. So, in truth, plasma is the major fraction of blood. It maintains colloidal osmotic balance, blood pressure, and blood volume and provides for the circulation of the red blood cells. The ultimate maintenance of the normal serum protein level depends upon the liver, which is the probable source of serum protein manufacture. Plasma may be produced directly, either from blood donors or as a by-product of the blood bank. Plasma may be collected from the unused blood in the blood bank by filtration about the eighth day after the blood is drawn, and then it can be pooled and stored ready for use.

Serum is the clear fluid expressed from clotted blood. It is nearly as good as plasma, but serum has no advantages over plasma. Very occasionally, serum produces a reaction, which is almost never true of plasma. Consequently, serum must occupy a position distinctly subordinate to plasma.

Concentrated human serum albumen comprises 65 per cent of the protein in blood plasma and exerts 85 per cent of the osmotic pressure provided by blood. Restated, this means that 100 cc. of 30 per cent human serum albumen exerts about the same osmotic pressure as 1,000 cc. of whole blood or as 500 cc. of blood plasma. In view of this great osmotic pressure, it must be remembered that concentrated human serum albumen may not be used alone in cases of dehydration. Parenteral fluids must be given at the same time or very soon after its administration. The armed services find 100 cc. vials of concentrated human serum albumen very convenient to use, and they also make very extensive use of dried or liquid plasma.

Less Effective Solutions

Hemoglobin Ringer's solution provides only temporary blood volume plus hemoglobin. This hemoglobin supply plays a markedly secondary role to that which is circulating or is mobilized by adequate blood volume.

Gum saline or acacia solutions bolster the circulating blood volume only temporarily, usually for a few hours. They remain in the circulation slightly longer than the crystalloid solutions.

It is doubtful if crystalloid solutions containing suspended red blood cells possess any significant benefit beyond that of the crystalloid solution itself. Only when anemia is very severe is the oxygen-carrying power of the blood depleted to the point of inadequacy.

Isotonic (i.e., physiologic) saline or isotonic (5 per cent) glucose leave the circulatory system very rapidly. It is doubtful that their effect persists for more than an hour.

Oxygen by inhalation in a high concentration is a valuable adjunct in cases of severe hemorrhage and shock. Experiments on dogs have shown that when 100 per cent oxygen is used, a 15 per cent greater blood loss can be tolerated, and the animals live 17 per cent longer than the controls.

The important role of vitamin K as a hemorrhage preventive in cases of hypoprothrombinemia deserves mention.

I have already spoken of the general principles of the control of ordinary exposed hemorrhage by pressure, simple first-aid measures, tourniquet, and early débridement surgery with ligation. The surgeon may find use for pressure packs or even chemical or organic hemostatic agents, such as tannic acid, ferric chloride, thromboplastic substances, and epinephrine. Recent experimental work suggests that rabbit thrombin may be an excellent local hemostatic agent because of its power to instantly precipitate fibrin.

Special Control Measures

Special problems in the control of hemorrhage arise in various locations of the body. Incised or perforated wounds of the heart call for immediate operation, suturing, and drainage of the pericardium into the pleura. Griswold reports numerous recoveries. Open wounds of the aorta are almost always fatal. Wounds of the larger arteries

generally require prompt surgical intervention to close the vessel wound, if possible, where adequate collateral circulation is impossible. Often the ligation of the artery and the associated vein is necessary if no peripheral pulse is present after the artery is ligated.

Traumatic hemorrhage of the brain and meninges calls for prompt surgery in cases of extradural (i.e., meningeal) hemorrhage. These cases are recognized by the so-called "lucid interval" interposed between two unconscious periods.

Internal hemorrhage may require surgical intervention, particularly in such conditions as ruptured ectopic pregnancy or, sometimes, bleeding ulcer. Many times trauma to the abdominal viscera, lungs, or mediastinal structures may be preferably handled by some nonoperative measures such as position, sedatives, oxygen, warmth and rest.

Summary

The treatment of traumatic hemorrhage requires prevention first of all.

Simple first-aid measures should be applied under circumstances permitting only the most immediate measures. Cleansing of the wound with débridement, ligature, or other surgical measures, sulfonamide therapy and wound care follow as facilities permit.

Whole blood is the best agent with which to replace lost blood. Plasma or serum albumen make excellent substitutes for blood and under many conditions are superior, chiefly because they require only a very few minutes to reach the patient. Simple colloid and crystalloid solutions have their effectiveness markedly limited because they leave the circulation rapidly. Oxygen, styptics, vitamin K, and thromboplastic substances have less value.

Injuries of special types or at special body locations call for individual control measures.

BIBLIOGRAPHY

1. Bowers, Captain W. F.: Nature and the Treatment of Shock, Mil. Surgeon 89:1 (July) 1941.
2. Brahdy, Leopold, and Kahn, Samuel: Trauma and Disease, Philadelphia, Lea and Febiger, 1937.
3. Brennan, H. J.: Plasma Transfusions in the Treatment of Haemorrhage, Brit. M. J. 1:1047 (June 29) 1940.
4. Buttle, G. A. H., and Kekwick, A.: Blood Substitutes in Treatment of Acute Haemorrhage, Lancet 2:507 (Oct. 26) 1940.
5. Ebert, R. V.; Stead, E. A., Jr., and Gibson, J. A.: Response of Normal Subjects to Acute Blood Loss, Arch. Int. Med. 68:578 (Sept.) 1941.
6. Ebert, R. V.; Stead, E. A., Jr.; Warren, J. V., and Watts, W. E.: Plasma Protein Replacement after Hemorrhage in Dogs with and without Shock, Am. J. Physiol. 136:299 (April 1) 1942.
7. Elliot, John: Blood Plasma, South. Med. & Surg. 103:252 (May) 1941.
8. Mitchiner, P. H.: Wound Shock, Haemorrhage, and Blood-Transfusion, Lancet 1:228 (Jan. 28) 1939.
9. Moon, V. H.; Morgan, D. R.; Lieber, M. M., and McGrew, D.: Similarities and Distinctions between Shock and the Effects of Hemorrhage, J. A. M. A. 117:2024 (Dec. 13) 1941.
10. Murray, C. R.: Treatment of Injury by the General Practitioner, New York, Harper and Bros., 1931.
11. Schnedorf, J. G., and Orr, Thomas: Oxygen Therapy in Shock due to Hemorrhage, Surg., Gynec. & Obst. 73:495 (Oct.) 1941.
12. Scudder, John: Shock, Blood Studies as a Guide to Therapy, Philadelphia, J. B. Lippincott Company, 1940.
13. Williamson, C. S.: Laboratory Aids of Value in the Diagnosis of Traumatic Shock and Internal Hemorrhage with a Brief Reference to the Use of Blood Plasma as a Therapeutic Agent, Wisconsin M. J. 40:570 (July) 1941.

GLYCERINE IN A NEW RUBBING ALCOHOL ALTERNATE

The curtailment of the use of ethyl alcohol, except upon prescription, for sponging and massaging purposes, has brought up the question of suitable alternates. Isopropyl alcohol solutions, containing glycerine, have been advocated as suitable substitutes for rubbing alcohol. The following solution has been recommended in both the *Journal of the American Medical Association* (121:630, 1943) and the *Journal of the American Pharmaceutical Association* (Pract. Pharm. Ed. 3:356, 1942) as a back lotion in place of the usual alcohol compounds:

Isopropyl alcohol	25.0 cc.	Acetic acid (4%)	2.5 cc.
Glycerine	10.0 cc.	Water, to make	100.0 cc.

The Management of Nontraumatic Hemorrhage*

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IN A discussion of the management of hemorrhage of nontraumatic origin, there are three factors that must be considered: first, the rapidity of bleeding; second, the origin of bleeding; and, third, underlying conditions which predispose the individual to hemorrhage. In the management of sudden, massive hemorrhage, such as occurs at times in cases of peptic ulcer or the rupture of esophageal varices, in which there is a profound disturbance in the dynamics of the circulation, the treatment is no different than that employed in sudden blood loss as a result of trauma, namely, the restoration of blood volume by transfusion, institution of methods to combat shock, direct attack on the source of bleeding, if accessible, and sedation applied to the patient as a whole or to the affected organ to promote blood coagulation. Inasmuch as there are some variations in the applicability of these principles depending upon the organ involved, I shall discuss briefly the method of management of a few of these hemorrhages of nontraumatic origin.

Peptic Ulcer

The problem of the management of hemorrhage as a complication of peptic ulcer is one of the most common with which the practitioner must cope. Bleeding occurs to some degree in 20 to 35 per cent of the cases, and duodenal ulcer is responsible for 60 per cent of the hemorrhages into the alimentary canal.[1] The severity of the bleeding varies from the small hemorrhage, manifested by a few tarry stools, which may occur repeatedly in the same individual without sufficient blood loss to cause systemic manifestations, to the sudden, profuse hemorrhage, in which a large amount of both fresh and clotted blood is vomited and the patient rapidly goes into collapse. As Palmer[2] has said, statistics on the frequency of hemorrhage as a complication of ulcer vary greatly, probably because of the flexibility in the definition of what constitutes "massive hemorrhage." If one accepts his definition, namely, the spontaneous vomiting of gross blood or the passage of tarry stools, then it is by no means a rare condition.

The tendency in the past decade has been to treat this complication in a less radical way medically and in a more radical way surgically. It is a far cry from the starvation program of Sippy to the liberal meals advocated by Meulengracht, and the decrease in mortality accomplished by the latter method is, as Palmer says, probably due to better neutralization of the gastric acidity by food. It is certain that control of gastric acidity is the most important single factor in the control of ulcer activity and that the means taken to accomplish this end is probably of secondary importance. The administration of food or of alkalis during the period of active bleeding seems to have resulted in a reduction in the immediate mortality.

When a patient is seen during or immediately after a profuse hemorrhage, it is important that measures for the control of shock be instituted at once. These include absolute bed rest, the application of external heat and use of morphine in sufficient amounts to allay restlessness and to diminish gastric motility and secretory activity. This usually means from 1/6 grain to ¼ grain hypodermically every four hours. The patient's blood should be grouped at once and carefully cross-matched with that of at least two donors. If the pulse is rapid and the blood pressure falling, transfusion should be carried out at once. Too much reliance should not be placed in the blood count of the patient, because an entirely erroneous impression of the condition of the blood in these dehydrated persons may be obtained because of hemoconcentration. There is no valid objection to giving large amounts of blood, provided it is given

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slowly so that there is no sudden increase in blood pressure. The flow of blood should be so regulated that not more than 5 to 7 cc. per minute is given. If this rate of flow is maintained, it is possible to give from 400 to 600 cc. of blood in one transfusion, and this may be repeated within twelve hours if there is evidence that the bleeding is not checked. It may be necessary, in some cases, to give one or two such transfusions daily for several days.

Bland foods and antacid medication may be given at once if there is no vomiting, but if vomiting is present, moderate amounts of normal salt solution by rectum and subcutaneously will prevent extreme dehydration. Fluids should not be given intravenously. Whether the Sippy diet with alkalis or some modification of it with aluminum hydroxide gel or the Meulengracht regime with liberal feedings is used will depend on the preference or courage of the individual physician and probably is of little consequence so long as adequate control of gastric acidity is accomplished.

After the acute episode of bleeding has passed, the ulcer symptoms have been controlled, and the blood has been restored to near normal level, a careful search for foci of infection should be carried out and any obvious foci eradicated. We have all seen ulcer patients with and without complications in whom adequate control was greatly facilitated by the removal of abscessed teeth or grossly infected tonsils. This may be accepted as an empiric clinical fact, whether or not one believes in focal infection as a factor in the etiology of ulcer.

Problem of Surgical Intervention

Not infrequently, when one of these patients is seen while he is desperately ill, the question of surgical intervention arises. It should be kept in mind that if the condition of the patient is so critical that the conservative measures outlined above will not save him, there is very little possibility that a major surgical procedure added to his burdens will increase his chance of survival. If profuse hemorrhage to the level of shock has occurred repeatedly so that the individual is in constant danger in spite of careful management, then surgery offers a means of satisfactory control. The surgeon should not be asked to operate upon an exsanguinated, debilitated patient, but every effort should be made by medical management and transfusion to bring about conditions as nearly ideal as possible. Then, if surgery is to be done, it should be carried out only by an experienced gastric surgeon who is able to perform skillfully the operative procedure most likely to result in lasting relief. This will usually mean resection of the ulcer-bearing area of the duodenum and most of the stomach. Even with this radical surgical treatment and its considerable danger, there is no absolute assurance that hemorrhage will not recur, and it is these factors which make one slow to advise operative intervention for a lesion that is seldom fatal. In the case of gastric ulcer, with the great possibility of malignancy, surgery should be advised at once if there is not prompt and positive response to medical management.

Hemophilia

Although it has been over 100 years since hemophilia was first described, the exact nature of the disease is still unknown. The only symptom of the disease is hemorrhage, and the only sign the prolonged coagulation time of the blood. The diagnosis of the disease rests upon the family history of hemorrhagic tendency affecting the male and transmitted by the female members, by prolonged hemorrhages from minor wounds, and by the history of frequent spontaneous hemorrhages into the large joints. While large, apparently spontaneous ecchymoses are common in this condition, petechial hemorrhages do not occur.

In addition to the prolonged coagulation time, other laboratory aids in the diagnosis of hemophilia are lengthening of the Howell prothrombin time, normal bleeding time from a skin prick, normal appearance of the stained blood smear, and a normal or elevated platelet count.

There is no satisfactory treatment for hemophilia. Among the myriad of substances advocated for use in the control of

bleeding, transfusion remains the most satisfactory procedure in the event of bleeding sufficiently severe to warrant it. When the bleeding is from a localized area, such as a tooth socket after extraction, the local application of fer-de-lance venom is very effective. Its subcutaneous or intramuscular administration as a prophylactic against hemorrhage into joints or under the skin has been disappointing. Dried thrombin or globulin substance in powdered form is also effective when applied locally for the control of superficial bleeding. The use of ovarian extract and female sex hormone to shorten the coagulation time of hemophiliac blood is based on the assumption, which has not been substantiated, that the female hormone is wholly lacking in these individuals. Their use has not proved to be of much value. Various tissue extracts, including extract of lung and placenta, have been used, and Eley[3] and his associates have reported the use of human placental extract in 20 hemophiliac patients, in whom they were able to reduce the coagulation time to ten minutes or less in 13 of the 20. They found the oral administration of this substance to be more effective than intramuscular injection. As in almost every other disease to which the flesh is heir, vitamins, especially B, C and D, have been used with no consistent effect. Many of the agents advocated are antigens and depend upon a maintained state of induced sensitization for their effect. Egg white and horse serum repeatedly injected have been advocated. Transfusion of whole or citrated blood acts very promptly to reduce the coagulation time of hemophiliac blood, and the effect usually lasts about twelve hours. So far as the effect on the coagulation time is concerned, a small amount of blood acts as promptly and as long as a large amount; therefore, unless the patient needs hemoglobin, there is no advantage in 500 cc. of blood over 100 cc. In the control of hemorrhagic crises, the repeated transfusion of small amounts of blood for inaccessible bleeding and the local application of snake venom or thromboplastin to bleeding points that can be reached are the most effective agents available.

Purpura Hemorrhagica

Purpura is one of the manifestations of a great many disorders of the blood and is, in itself, of no specific diagnostic significance. Although the symptom complex known as hemorrhagic or thrombocytopenic purpura was differentiated from other blood diseases by Werlhof in 1775, little is known today of the pathologic physiology responsible for it. Since Kaznelson, in 1916, demonstrated that splenectomy would cure the condition, this procedure has become the standard treatment for chronic cases in which the symptoms are severe enough to warrant it. The results have been uniformly good in well established cases. The treatment for the more infrequent acute cases is less well defined. Most text books still state that splenectomy is contraindicated in the acute case, although they fail to define what is meant by the term "acute." If one accepts the definition of the acute case as one in which spontaneous hemorrhage into the skin and internal organs occurs without trauma and without previous history of hemorrhage, then more sound advice would be that splenectomy is contraindicated until the diagnosis of hemorrhagic purpura is established beyond reasonable doubt and other means to control the bleeding have failed.

The diagnosis of hemorrhagic purpura is not easy. The following points, as set forth by Eliason and Ferguson,[4] may be used as a basis for differentiating it from other disorders of the blood in which bleeding may be a prominent symptom: "(1) 'Spontaneous extravasation of blood into or under the skin and mucous membranes of the body.' (2) Diminished platelet count. (3) Prolonged bleeding time. (4) Approximately normal coagulation time. (5) Absence of clot retraction. (6) The appearance of petechiae in the skin distal to a tourniquet blocking the venous but not the arterial flow. (7) Secondary anaemia without constant changes in the red blood-cells. (8) No constant variation in the white blood-cells, but usually an increase rather than a decrease." Of these, the most important are diminished platelet count, prolonged bleeding time with normal coagulation time, positive tourniquet test, and normal or increased leucocyte count.

The diseases most likely to cause difficulty in differential diagnosis are acute aplastic anemia, hemophilia, and acute aleukemic leukemia. Hemophilia is characterized chiefly by the family history of hemorrhagic tendency, the normal bleeding time, and prolonged coagulation time with normal retractility of the clot after it has formed. Acute aplastic anemia with purpuric manifestations may be very difficult to differentiate, but the proportionate diminution of all the formed elements of the blood and the absence of reticulocytes in the presence of severe anemia are helpful findings. As a practical indicator, the leucocyte count is the best guide, and one should be very doubtful of a diagnosis of hemorrhagic purpura in which there is leukopenia. Aleukemic leukemia is characterized by the presence of immature white cells, but it is easier to speak of these cells than to recognize them.

Once the diagnosis of acute hemorrhagic purpura is established beyond doubt and the bleeding continues after conservative measures have been tried, I have no hesitancy in recommending splenectomy. To one who has never seen the sudden cessation of bleeding in one of these cases as soon as the spleen is removed, no words can adequately describe the phenomenon. It is as near a miracle as anything I ever expect to see. In a case occurring in a young man which I reported in 1929,[5] the urine and stool on the morning of operation had the appearance of pure blood and coagulated on standing. The first urine passed after splenectomy contained only a few shreds of clotted blood. That man is still living and has had no recurrence of bleeding of any kind. In addition to stressing accurate diagnosis, the only word of caution I would speak is to emphasize what Marsh[6] has said, that these patients must be properly prepared for operation by adequate transfusions, so that although they have been cured of their disease they will not die of the shock of operation.

Hemorrhage Associated with Prothrombin Deficiency

1. *Obstructive Jaundice*

Bleeding after surgical procedures performed on patients with obstructive jaundice has been a serious complication. While it was not a particularly common occurrence, it was difficult to control and accounted for fully half the surgical mortality incurred in operations for this condition. The history of the discovery and development of vitamin K as an effective agent in the control of cholemic bleeding is so recent and well known that only the high lights will be sketched.

In the course of experimental work on lipoid metabolism, Dam made the observation that newly hatched chicks, when put on a fat-free diet, developed hemorrhage into the skin and mucous membranes. He deduced from this that some substance dissolved in the fat was essential to proper blood coagulation in chicks and named the substance Koagulation vitamin, or vitamin K. Subsequent work showed that the administration of the fat soluble antihemorrhagic vitamin by mouth together with bile salts to insure absorption would control this hemorrhage. Clinical application of these observations has been developed in several groups in this country, especially those at Iowa City and Rochester.

Quick[7] and his associates determined that prothrombin is the factor in the clotting formula that is deficient in avitaminosis K. Quick[8] has also devised a quantitative test for prothrombin which is extremely valuable in determining which case of jaundice is in danger of hemorrhage and when such danger has been overcome. Inasmuch as prothrombin is apparently synthesized by the liver, the functional integrity of this organ is essential to the proper action of vitamin K, and, in those cases in which the Quick prothrombin clotting time is prolonged and does not respond to vitamin K therapy, the fault probably lies in this organ. In such cases, a high vitamin diet, intravenous dextrose, and calcium are sometimes effective in restoring liver function sufficiently so that vitamin K will increase the prothrombin level to a point where bleeding will not occur.

More recently, naphthoquinones having vitamin K activity have been synthesized and found to be effective when given parenterally in lowering the prothrombin clotting time of a patient afflicted with jaundice. This obviates much of the difficulty in ad-

ministering the vitamin and bile salts to these patients before and after operation on the biliary tract. During the postoperation period, if difficulty is experienced in keeping the prothrombin level above the danger zone, transfusion of fresh, citrated blood will raise the prothrombin level for about twelve hours and thereby bridge a critical period in postoperative recovery.

2. *Hemorrhagic Disease of the Newborn*

During the period between the second and sixth day of life, there is a normal or physiologic hypoprothrombinemia in infants. It is during this period that the greatest danger of intracranial hemorrhage exists. It has been found by numerous investigators that vitamin K administered to the mother before delivery will prevent this temporary fall in the prothrombin level. Since the introduction of vitamin K active substances which can be given parenterally, Bohlender and his associates[9] have shown that the intravenous injection of this substance into the mother even during labor will increase the prothrombin level in the infant's blood. They recommend that it be given routinely as a prophylactic measure and urge its use in cases in which the infant is likely to be premature, in which the labor is prolonged, or in which operative delivery of any type is anticipated.

Summary

The treatment of duodenal ulcer complicated by massive hemorrhage is primarily medical and should be directed toward healing the ulcer by adequate control of gastric acidity. Transfusion of blood should be utilized whenever the bleeding is sufficiently severe to warrant it. If medical control is impossible and hemorrhage recurs in spite of the most careful management, surgery should be undertaken only by experienced gastric surgeons after the patient is thoroughly prepared.

Hemophilia is best controlled by small transfusion for inaccessible hemorrhage and local application of thromboplastic substances for bleeding points that can be reached.

Thrombocytopenic purpura is cured by splenectomy. This procedure should be utilized in both acute and chronic cases when symptoms are sufficiently severe to warrant it.

Vitamin K and naphthoquinones having vitamin K activity are effective in the prevention of hemorrhage in cases of prothrombin deficiency provided the liver is functionally adequate.

BIBLIOGRAPHY

1. Rivers, A. B., and Wilbur, D. L.: The Diagnostic Significance of Hematemesis, J. A. M. A. 98:1629 (May 7) 1932.
2. Palmer, Walter, in Barr's Modern Medical Therapy in General Practice, Baltimore, The Williams and Wilkins Company, 1940.
3. Eley, R. C.: The Clinical Application of a Coagulant Substance Obtained from the Human Placenta, J. Michigan M. Soc. 36:377 (June) 1937.
4. Eliason, E. L., and Ferguson, L. K.: Splenectomy in Purpura Hemorrhagica, Ann. Surg. 96:801 (Nov.) 1932.
5. Killins, W. A.: Acute Thrombocytopenic Purpura Cured by Splenectomy, J. A. M. A. 92:1832 (June 1) 1929.
6. Marsh, H. E.: Splenectomy in Acute Haemorrhagic Purpura, Ann. Surg. 91:313 (Feb.) 1930.
7. Quick, A. J.: The Coagulation Defect in Sweet Clover Disease and in the Hemorrhagic Chick Disease of Dietary Origin, Am. J. Physiol. 118:260 (Feb.) 1937.
8. Quick, A. J.: Stanley-Brown, Margaret, and Bancroft, F. W.: A Study of the Coagulation Defect in Hemophilia and in Jaundice, Am. J. M. Sc. 190:501 (Oct.) 1935.
9. Bohlender, G. P.: Rosenbaum, W. M., and Sage, E. C.: Antepartum Use of Vitamin K, J. A. M. A. 116:1763 (April 19) 1941.

THE TUBERCULOUS WORKER IN THE WAR EFFORT

The successfully treated part-time or full-time tuberculous worker can contribute to the manning of the war industries with great benefit to the nation and to the worker himself. A risk is present, but if workers are chosen on a sound medical basis, the risk is not great and is worth taking particularly in the present emergency. Plans must be made also for the future tuberculous service men and civilian war workers. The expansion of the facilities for training and placement of tuberculous workers is necessary. The establishment of workshops for industrial convalescence and perhaps colonies for chronic patients is called for. Louis E. Siltzbach, M. D., Milbank Memorial Fund Quarterly (Jan.) 1943.

Making Ration-Limited Diets Adequate

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DIFFICULTY in purchasing the foods usually included in an adequate diet is leading many laymen as well as physicians to wonder whether an increased incidence of nutritional deficiency is to be expected in the United States during the war period. It is common practice to avoid any such risk by using concentrates of vitamins as adjuvants to the diet, assuming that no deficiency other than one of vitamins is probable. These assumptions and conclusions can be examined in simple fashion.

In a recent paper, Dr. F. C. Bing,[1] of the Council on Foods and Nutrition of the American Medical Association, describes the manner in which an adequate diet may be secured without any recourse to vitamin concentrates or special foods:

"*Milk.* Two or more glasses daily for adults; 3 or 4 or more glasses daily for children. This may be drunk as such or combined with other foods.

"*Vegetables.* Two or more servings daily in addition to potatoes. Preference should be given to the green leafy and the yellow vegetables because of their vitamin A. One vegetable might well be eaten raw if it is a good source of vitamin C.

"*Fruits.* A serving or more of fruits is desirable but preference should be given to fruits which contribute vitamin C. Citrus fruit and tomatoes (some will consider this a vegetable) are outstanding sources, and the commercially canned products are as good as the fresh.

"*Meats and Other Protein Foods.* There should be one serving of meat for its protein content. Additional servings will supply more protein and more thiamine, riboflavin and nicotinic acid which meats provide. Fish, cheese and legumes also provide proteins but as a rule are poorer in the B vitamins. Eggs are valuable protein foods and also supply some iron and riboflavin and vitamin A.

"*Cereals and Bread, and Butter and Other Fats.* These are the energy foods. In selecting them it is well to choose those items which contribute additional food values. Thus the cereal products ought to be whole grain or enriched. Fats ought to be butter which contains vitamin A. If oleomargarine is used for economy, then it would be well to select that which supplies added vitamin A."

Meat

Attention should be called first of all to the meat allowance, which is assumed to be four ounces daily. If this is translated into a weekly twenty-eight ounces, and if addition of one fourth is made to cover bone, fat, and the shrinkage on cooking, the total becomes two and one-fourth pounds. This equals or exceeds the rationed allowance in force at present. Of course, the use of fish and poultry and eggs will be an aid. It becomes important that there is some ground for concern lest unwise use of the limited purchasing power should secure less protein and less of the B vitamins than is considered necessary.

Cereal Grains

Use of increasing amounts of cereal grains in any form will augment the total protein intake. The quality of protein is not as good as that in meats and therefore, must not be relied on for a large share of the pro-

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[1] Bing, F. C.: Foods As Sources of Nutrients, M. Clin. North America 27:299 (March) 1943.

tein supply. If most of the cereal grain is in the form of baked foods made from the modern enriched flour, the intake of thiamine, riboflavin, nicotinamide, and calcium will be improved. But unless the bread intake is at least six slices per day, these additions will not be of major importance in a restricted diet.

Milk

One of the best possible supplements to a questionable diet is the use of milk in such amounts as one to two pints per day. This still needs to be urged on adults. Every opportunity to include milk, even skim milk, should be sought. This will improve the intake of calcium, riboflavin, thiamine, and especially of excellent quality protein. But there is little prospect of any significant expansion of the production of milk during the immediate future.

Butter Fat

Further attention is directed to the advice in Dr. Bing's paper that most of the fat should be butter fat. With the drastic restriction on butter fat now in force, this is impossible in practice. It is questionable how long cream can be kept free from rationing restrictions since production of butter fat cannot be increased rapidly. This limitation tends to reduce the intake of vitamin A, for the better sources of this vitamin are from butter, cream, and cheese. The value of skim milk as a source of vitamin A is not to be underestimated, but again we must recall that this portion of milk cannot be produced in greatly increased amounts. It does seem wiser to use skim milk or milk solids for human food rather than for the manufacture of plastics. This is merely a suggestion that the American people ought to learn to eat more skim milk products.

Fresh Fruits and Vegetables

Another aspect of food restriction is the increasing value put on fresh fruit and vegetable food, counterbalanced by the rapidly increasing difficulty in purchasing adequate amounts of these perishable foods. The principal nutritional value in fresh foods is the supply of ascorbic acid, vitamin C. Although citrus fruits are the best sources of this vitamin per pound of food, there is no possibility of securing at present an adequate supply of citrus fruit for the entire population of the United States. Tomatoes represent the next best source of vitamin C, and there ought to be a tremendous expansion of the planting of tomatoes this spring. Canned tomatoes retain their vitamin C very satisfactorily. Fresh cabbage is another excellent source and has the merit of retaining vitamin C during fairly long periods of storage. In addition, a number of the highly seasonal fruits, especially some of the berries, are of importance.

Synthetic Vitamin C

Due to the perishable nature of fruits and of the vitamin C they contain, the increasing cost of fresh foods, the rationing restrictions on canned juices, and transportation problems, there is a rapidly growing dependence upon synthetic vitamin C. The daily requirement of this vitamin was formerly thought to be about 30 mg. per day, but more recent observations on humans indicate a need of 75 or more mg. daily. The alarming feature of this source of vitamin supply is that the manufacturing capacity of the few plants making vitamin C is far less than the present demand and that for the present there is less vitamin C available than the domestic market calls for. Incidentally, there is a tremendous requirement for export of this vitamin to our allies.

Vitamin D

The supply of vitamin D is always one of the more critical factors in a human nutrition program. Unless there is a planned and extensive exposure of the skin of the body to direct sunlight or to ultraviolet light, adequate vitamin D is seldom available to children even in a carefully selected diet of natural foods. Supplementation with cod liver

oil, or some of the more modern potent substitutes, is now recognized as of essential nature. But cod liver oil production is being seriously reduced by fishing limitations along the Atlantic seaboard. In some urban areas, adequate intake of vitamin D is assured by the use of milk fortified with this vitamin in one of several ways. But this safeguard is not made available in rural areas or in those communities whose dairies have not yet undertaken to irradiate or fortify the milk. The great majority of the population is without this simple safety measure. There is an increasing conviction among nutrition workers that the adult requires this vitamin, although the amount needed cannot be estimated by methods now known.

With all these difficulties, there are many physicians who will feel inclined to agree with those who say "Why worry about getting all the vitamins from natural foods when the whole daily requirement can be bought so cheaply in one capsule?" The progress of synthetic chemistry, quantity production, and national distribution have actually made it possible to secure for not over 6 cents each day all the vitamin A, thiamine, riboflavin, nicotinamide, ascorbic acid, and vitamin D that are needed by a growing child or an adult. Many of these capsules include also some pyridoxine and pantothenic acid, even though the human need for these vitamins has not yet been determined. In the tabulated data at the end of this article are found the names of several such products, together with the vitamin content in each of these factors. Comparisons can be made with the minimum daily requirement for each as recognized by the United States Food and Drug Administration. This is a very conservative allotment. The Food and Nutrition Committee of the National Research Council has adopted, at a slightly later date, a statement of Recommended Daily Allowances of these same materials. This attempts to specify the amounts for different ages and body requirements and is presented here in condensed form for comparison.

Capsules to Supplement Deficient Diets

In judging any commercial product, it is suggested that two standards be kept in mind. If the product is desired for therapy, it may well be of high potency, perhaps even more than the daily allowances of the Food and Nutrition Committee. But for the present point of view, that is of supplementing a possibly deficient diet, the need is for a capsule which will give from one-half to all of the daily need in one capsule. If one uses the maximum adult allowances of the more liberal recommendation as a guide, then those two products marked with number 1 will provide the entire daily ration by use of one capsule. Similarly, the ten marked ½ will provide approximately one-half the daily ration of all the vitamins listed. The two products not so marked contain too little vitamin C for such approval.

There are other features which will be urged by the promoters of certain specialties, such as the inclusion of other factors from yeast, liver, or the outer coats of grains. These components of the B complex may be of significance in human nutrition. Of this we are still uncertain. The clinician may prefer to use a vitamin mixture based on yeast, or liver, rather than on purely synthetic sources of B vitamins, to avoid deficiencies in unknown B factors. Probably this is unimportant in comparison with the other aspects of adequate diet. The amounts of yeast or liver included in such multivitamin capsules usually cannot be significant.

In view of the obvious shortage of A, riboflavin, and ascorbic acid, it is urged that these materials be used with attention to economy, for there is no benefit to be obtained by gross excess intake of any of these vitamins. This suggestion does not apply to the use of any specific vitamin in the treatment of disease, but merely to the use of vitamin concentrates in fortification of diets which may become inadequate because of the temporary dietary difficulties which the American people face for the next few years.

FIRM	PRODUCT	Probable Retail Cost per 100	Content of Each Capsule								Rating
			Units	Milligrams						Units	
			A	B-1	B-2	Niacin	B-6	Panto.	C	D	
Abbott	Dayamin	7.74	5000	3.	2.	20	1.	1.	50	500	½
Armour	D.A.B.S.	4.82	5000	1.	2.	10	--------	--------	25	700	½(?)
Lilly	Multicebrin	8.00	5000	3.	2.	20	1.	1.	50	500	½
Parke-Davis	Abdec	6.94	5000	1.5	2.0	10	1.	3.	50	500	½
Sharp & Dohme	Esdavite	4.50	5000	1.	2.	10	--------	--------	30	500	½(?)
Squibb	Pargran–V (Note 1)	9.00	4500	1.5	2.25	15	--------	--------	60	600	½
	Engran	8.25	5000	3.	3.	20	1.	3.	75	800	1
	Special Vitamin formula	6.00	5000	2.	3.	20	--------	--------	75	800	1
Standard Brands	Stams (Note 1)	5.25	5000	1.	2.	10	0.25	0.5	30	500	½(?)
Stearns	Multiple vitamin capsules	3.98	5000	2.	2.	25	0.25	0.5	30	800	½(?)
Upjohn	Unicaps (Note 2)	3.95	5000	1.5	2.	20	0.2	1.	10	500	½(?)
White	Neo Multi-Vi	5.69	5000	1.5	2.5	20	1.	1.	50	500	½
Winthrop	Polytaxin	3.50	4000	1.	2.	10	--------	--------	30	400	½(?)
Recommended Daily Allowances	Children		1500—6000	0.4—2.0	0.6—3.0	4—20			30—100	400—800	Committee on Food and Nutrition, National Research Council.
	Adults		5000	1.2—2.3	1.8—3.3	12—23			70—75	400	
	Pregnancy		6000	1.8	2.5	18			100	400—800	
	Lactation		8000	2.3	3.0	23			150	400—800	
Minimum Daily Requirements	Children		1500—5000	0.25—0.75	0.5	--------			10—20	400	United States Food and Drug Administration
	Adults		4000	1.0	2.0	10			30	400	
Hexavitamin Capsules			5000	2.	3.	20			70	4000	U.S.P. XII

It must be understood that the prices given are not guaranteed, and that retail prices are determined by the retailer. The composition of these capsules is subject to alteration because of changing concepts of need and especially because of emergency conditions affecting supplies.

The designation ½ indicates that one capsule daily will provide approximately one-half the recommended daily allowances of all vitamins. The use of ½ (?) is to call attention to products which are slightly too low in vitamin C.

Note 1. *Pargran* and *Stams* are prepared with expectation that the daily dose will be divided into 3 tablets. The vitamin content is calculated per 3 tablets. The prices are also quoted as for 100 daily doses of 3 tablets each.

Note 2. The low ascorbic acid content is a temporary adjustment due to restricted supply, and the amount is scheduled to be raised significantly at an early date, justifying placing Unicaps in the "½" group.

Comments on Treatment

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The Ascorbic Acid Requirements of Infants and Children*

Observations of children 2 to 12 years of age have shown that a daily intake of 0.5 mg. of ascorbic acid per pound of body weight will maintain fasting blood levels of this vitamin at 0.7 to 0.8 mg. per 100 ml/ of plasma. For children of this same age group, a daily intake of 1.0 mg. of ascorbic acid per pound of body weight will maintain levels of 1.0 to 1.2 mg. of this vitamin per 100 ml/ of blood plasma. This latter level corresponds to tissue saturation with this vitamin and can be considered optimum for health and growth.

In similar observations on infants, it was found that those under 9 months of age required 1.0 mg. of ascorbic acid daily and per pound of body weight to maintain a fasting level of 0.7 to 0.8 mg. of ascorbic acid per 100 ml/ of blood plasma, and at least 2.0 mg. of this vitamin per pound of body weight to maintain an ascorbic acid content of 1.0 to 1.2 mg. per 100 ml/ of plasma. It is, therefore, apparent that young infants have an unusually high requirement for ascorbic acid by comparison with older infants and children.

These data were obtained from observations of infants and children whose diets were carefully controlled with respect to ascorbic acid intake and which provided adequately for other nutritive requirements. The food contained from 3 to 5 mg. of ascorbic acid daily, and the remainder of the ascorbic acid intakes were provided as doses of chemically pure vitamin.

In the course of these studies, it was also found that the plasma levels of ascorbic acid of infants under 9 months of age fell from a level indicative of tissue saturation to one of zero value in about seven to nine days when the ascorbic acid intake was reduced to a total of 3 to 5 mg. per day.

It has been well established that the usual range of ascorbic acid in human milk secreted by mothers receiving an adequate supply of ascorbic acid in their diets varies from around 6 mg. to 8 mg. per 100 ml/ of milk. By comparison, pasteurized cow's milk and reconstituted evaporated cow's milk carry on the order of 1.5 and 0.5 mg. respectively of ascorbic acid per 100 ml/. It is obvious, therefore, that a very young infant receiving 600 ml/, or about 20 ounces, of milk daily may receive around 40 mg., 9 mg. or only 4.5 mg. of ascorbic acid per day depending on the source of the milk provided. It is fairly general practice to include small amounts of orange juice in infants' diets after they have reached the age of 1 month. An ounce of fresh orange juice provides about 15 mg. of ascorbic acid.

In view of these observations summarized above, together with consideration of the frequent practice of preparing the artificial feeding formulae for infants with evaporated milk, it is clear that young infants on such artificial feeding programs are limited to about 10 per cent of an adequate intake of ascorbic acid for the first month of life. With introduction of small amounts of orange juice after the first month of life, their intake of ascorbic acid is still too low for the best interests of good nutrition. Infants that are breast-fed by mothers whose intake of ascorbic acid is adequate have a proven nutritional advantage as regards adequacy of ascorbic acid intake over those fed on any type of cow's milk formula. The nutrition of the artificially fed infant could be distinctly improved by addition of ascorbic acid to the artificial feeding formula in quantities which would provide ascorbic acid equivalent to that available to the completely breast-fed infant.—LELA E. BOOHER, Ph. D. *chief nutritionist for General Mills.*

* A summary of research work conducted at Milwaukee Children's Hospital, Milwaukee, in 1942.

The Technic of Home Canning

By DOROTHY L. HUSSEMANN*
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FOREWORD TO PHYSICIANS

DURING the summer of 1943, home food preservation will undoubtedly reach heights not attained in recent years. Point rationing, Victory gardens, and stimulation through the press and the radio would seem to lead inevitably to such a result. This will mean, then, that in many families such preservation processes will be carried on for the first time. Desirable as such home preservation is in the present war emergency, it must be realized that when canning is in the hands of inexperienced people, certain dangers to health are involved of which they are unaware. It is true, perhaps, that the rural population has had much wider experience and has been better informed through state and federal agencies concerning these processes than has the urban population. Steps are being taken by certain agencies to reach this latter group this year. Even so, it seems unlikely that all people interested in having an auxiliary supply of home preserved food, over and above that permitted by the rationing system, can be reached in time to avert some disastrous results. Such, at least, has been shown to be the case when, in the past, the people of the country have tried to help themselves by preserving food at home, particularly by canning. Within the last thirty years, there have been two periods of great stimulation to canning. One of these occurred at the time of World War I, and the other occurred during the so-called depression years. Available and relatively complete records of the results of the second of these periods of home canning show such food to be a significant source of danger to health.

The Physician's Responsibility

The physician is in the singular position in a community of being sought for advice concerning matters of health. With home food preservation greatly on the increase, this becomes a community health problem and, in many regions, must become an added responsibility for the already overworked doctor.

During the coming summer, home food preservation may present a significant problem in the maintenance of good health. The families concerned will undoubtedly be grateful for any advice given them by members of the medical profession in regard to safe methods of home food preservation. In turn, whatever suggestions these physicians may offer will ultimately be to their own advantage, in that any large-scale or disastrous food poisoning would take, in ever greater measure, their time and energy.

The paper to which this is a foreword describes in some detail the proper canning technics and indicates the particular points at which there is either danger of contamination or loss of food value. It is hoped that the physician will find this a useful supplement to the advice extended by him to potential home canners.

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REPRINTS

Reprints of the following article on the Technic of Home Canning may be obtained by writing the office of the State Medical Society, 917 Tenney Building, Madison.

Cost—5 cents per copy in quantity orders.

The Foreword to Physicians on this page will be omitted so that the reprints may be distributed to patients or friends who inquire concerning home canning.

Methods of Food Preservation

There are several choices available to the families in the community who are selecting a method for home food preservation. Among the methods listed are canning, freezing, drying, brining, and common storage. The family must select its method in view of the type of food, the equipment available, the space for storage of the final product, and the cost. However, it is a safe guess that a very large part of the food preserved during this coming summer will be done by canning, because it is a well known method and lends itself to many types of food. As far as the health aspects are concerned, there are at least two types of danger inherent in the use of this method. The first is the very tangible danger of disease resultant from contamination of the food in some way during the preparation. The second is the less immediately measurable danger of possible malnutrition due to a change in food value in the home preserved foods.

Because it is believed that "an ounce of prevention is worth a pound of cure," the canning procedures which have proved to be scientifically sound and practically successful will be outlined briefly. The outline will consist of a somewhat detailed description of the proper canning technic and will indicate the particular points at which there is either danger of contamination or loss of food value.

The basis of the canning method is the obtaining of a practical sterilization of the food by the use of heat and the maintenance of the food in a sterile condition. Elimination of representatives of all types of microorganisms, namely, bacteria, yeast and molds, as well as the action of certain of the plant enzymes, make up the problem in its entirety.

Selection of Food to Be Canned

The first consideration is the selection of the fruits and vegetables. Only those which are of prime quality should be included. At this time, the enzymes have brought about all desirable changes as far as ripening and maturing are concerned, but they have not yet tended to overripen the plant and, hence, to cause softening, which makes for easy entrance of bacteria, yeast and molds. Such fruits and vegetables are of excellent color and flavor. If first quality fruits or vegetables for canning have been obtained, it would be needless waste to let the food stand around, especially at room temperature. Under such treatment it would be subject to continued enzyme action. This enzyme action might, in turn, soften the tissues and allow micro-organism attack. Therefore, a well established rule of successful home canning is "two hours from garden to can." Obviously, if one cannot avoid holding the food for a great length of time, then it should be placed in a cool, well ventilated place and held in small lots.

Because the factor which determines how a food should be finally processed in canning is the acidity of the food, this must be considered when the plans are being made. The degree of acidity is important, because it determines in a large measure the ease with which the food during processing will be freed of contamination by the dangerous organism, Clostridium botulinum. When being canned, the so-called acid foods, which include fruits, tomatoes, pickled beets, ripe pimentos, and rhubarb, are less likely to become infected by Clostridium botulinum than other foods. The nonacid foods include all other vegetables, such as asparagus, peas, beans, and corn. The nonacid foods have pH values somewhat below 7, but the values approach neutrality; hence, for convenience, the canner classifies these foods as nonacids. The question often arises as to the feasibility of making nonacid foods acid by the addition of small amounts of vinegar or lemon juice and thus making for easier processing. However, recalling the buffering action of the salts of the plant material and, in the case of vinegar, the volatibility of the acid, one concludes that such a procedure is useless unless large quantities of acid are added, as in the pickling of a vegetable. The use of canning powders is discouraged because successful canning is possible without them, and their physiologic reaction may be dubious.

Cleaning of Food

Following consideration as to the acidity of the food, one is ready to proceed with the

canning. Final processing will be made easier and more effective if every effort is made to keep micro-organism contamination at a low level throughout the procedure. To this end, all foods should be cleaned very thoroughly. If necessary, they should be washed repeatedly to free them of all soil. However, because it is disadvantageous to allow the food to stand around in water, it should be rapidly lifted out of its washing water.

The cleaned food may then be put directly into clean, hot jars which have been examined so that any chipped or cracked ones are detected and eliminated. Water or sirup is then added to the food in the jar, the cover of the jar fastened into place, and the food processed. This is the so-called "cold pack" method of canning. However, the method which is being looked upon with more and more favor is the "hot pack." Hot packing allows for a very quick preheating before the food is put into the jar. The hot pack is advantageous because heat penetrates the plant tissue quickly by such a procedure, because there is greater ease of sterilization, and because the food shrinks, becomes more pliable, and thus is more easily packed.

The Liquid-to-Solid Ratio

In the case of fruits, hot packing is done by adding sugar to taste directly to the fruit and then heating to the boiling point, with enough stirring to avoid burning. For some of the less juicy fruits, the amount of liquid so obtained may not be sufficient to permit bringing the fruit to a boil without scorching, and small amounts of water may have to be added. Moreover, the less juicy fruits may have to be sliced before the sugar is added in order to get the largest possible yield of juices. This technic of sugaring the fruit is one that is being suggested for use during the current war emergency, because it lowers the quantity of sugar necessary for the canning. It must be realized that the fruit will not have the same perfection of shape that was obtained by bringing the fruit to a boil in a sirup made of sugar and water as was done before the war. In any event, this hot fruit is packed into clean, hot jars quickly enough so that it remains hot, and a spatula is inserted along the side of the jar to facilitate removal of entrapped air within the jar. The liquid-to-solid ratio should be in such proportion as to avoid too dense a pack, and the solid material should be covered by liquid. The rim of the jar is wiped to remove food particles, and the jar cover is put on. The food is now ready for processing. It is of decided advantage to work with only small quantities of food at one time and, once having begun, to carry the lot through final processing rather than use large quantities of food and have the process prolonged at each step.

For the acid foods, processing will be adequate if it is carried on for a sufficient length of time at the boiling point of water. The boiling point of water may be reached by processing the food in a water-bath, in a steamer, or in an oven. It is felt that the water-bath yields a superior product.

The oven is not quite so satisfactory as the water-bath because heat is transmitted more slowly by air than water, and the processing time for the oven must necessarily be about one and one-half the time for processing in the water-bath. Moreover, because the glass of the fruit jar becomes hot in the oven, the fruit lying against the glass may tend to brown due to carmilization of sugars. Loss of liquid from the jar also causes difficulty in oven canning. The steamer is not quite so satisfactory as the water-bath because it requires more care to its operation. Too often the inexperienced person tries to put too many jars into the steamer or does not have a sufficient head of steam, and, in either case, spoilage of food may result.

A water-bath may be made from any boiler or kettle that has a tight fitting cover, is sufficiently deep to allow one-half inch of water over the tops of the jars, has available a false bottom or rack on which to set the jars, and will hold enough jars at one time to be practical. The length of time for processing any of the fruits can be found by reference to Farmers' Bulletin 1762 published by the United States Department of Agriculture or to the canning bulletin published by the Home Economics Division of the University of Wisconsin. After the processing is complete, the jars are removed

WHAT VEGETABLES DO FOR US

The Body Needs:			It Gets Them From:
ENERGY	Carbohydrates	Starches	*Potatoes and other starchy vegetables* Cereals
		Sugars	Sugar and syrup Honey and molasses
	Fats		Butter and cream Meat fats Cheese Other fatty foods
BUILDING AND REPAIR MATERIALS	Proteins		*Beans and peas* Meats Dairy products and eggs Cereals
	Minerals	Calcium	*Green vegetables* Dairy products
		Phosphorus	*Beans and peas* Meats Cereals (whole grain) Dairy products and eggs
		Iron	*Green vegetables* Meats and eggs Cereals (whole grain) Dried fruits
REGULATORY AND PROTECTIVE FOODS	Vitamins	A	*Green and yellow vegetables* Dairy products Fish liver oils
		Thiamin	Cereals (whole grain) Meat *Green vegetables*
		Riboflavin	Meats *Green vegetables* Milk and eggs
		Nicotinic Acid	Meats Whole grain cereals *Beans and peas*
		C	*Tomatoes and cabbage and other raw vegetables* Fruits
		D	Fish liver oils Dairy foods Eggs

from the water-bath and set out of a draft but in such a fashion as to allow air to circulate among them in order to cool the jars as quickly as possible.

In the preparation of the nonacid foods, a somewhat similar technic is followed. Following the cleaning of the vegetable and the cutting of it into whatever shapes or sizes are desired, it is immediately plunged into a small amount of boiling water and heated briefly, usually for two minutes. The hot vegetable is then placed into the clean hot fruit jar, and the liquid in which the vegetable was heated is added, with the same precautions of packing as were indicated for the acid food. In this case, there is no completely safe alternative for processing the food in a steam pressure cooker. The jars of food are placed into the pressure cooker, and water to the depth of one inch is poured in. The cover is clamped on securely, the petcock is left open, and heating is begun. After steam has come out of the petcock for a period of five to seven minutes, the petcock is closed, and the pressure is allowed to rise to the desired amount. Times for heating in the pressure cooker may also be found in the Federal Government bulletin on canning (Farmers' Bulletin 1762) and in the University of Wisconsin bulletin. At the conclusion of the processing time, the pressure cooker is removed from the source of heat, the pressure is allowed to return to zero, and the petcock is loosened before the cooker is opened. When removed from the pressure cooker, the jars of food should also be cooled quickly.

Botulism

The chief danger of these canned foods to health is, of course, botulism. Reported case histories indicate that no outbreak of botulism poisoning due to food commercially canned in the United States has been recorded since 1925. That puts the issue squarely up to control of home canning methods. Botulism causes extreme physiologic distress and is a disease which is often fatal in its outcome.

The avoidance of this disease is believed to be entirely a matter of obtaining a thorough sterilization in the processing of the food canned. The active agent in the cause of the disease is the toxin given off by Clostridium botulinum. While in many cases the food will appear to have unusual odors when the can is opened, it is also unfortunately true that there are times when the food will appear not to have changed. Because the housewife is then unable to be forewarned, the food is eaten with serious results. It has already been stated that acid foods are processed at the boiling point of water. The combination of acid plus this degree of heat for the recommended length of time seems sufficient to destroy the cells of Clostridium botulinum with the consequent elimination of the formation of the toxin. The nonacid foods, however, require a higher temperature in order to sterilize them, and, for safety's sake, all foods of this group must be heated to a temperature above the boiling point of water. Only through the use of the steam pressure cooker in processing can nonacid canned foods be regarded safe for human consumption.

It is a well known fact that many housewives in the past have used methods of processing nonacid foods other than the steam pressure canner method with no observable ill effects. It must be recognized that this is merely good fortune and that repeating the process may result in harm to themselves and their families. The success of the water-bath or methods other than the steam pressure canner for nonacid foods would indicate that there was no original contamination of Clostridium botulinum present. Should such a contamination be present, these methods which subject food only to the boiling point of water are ineffective. Women cannot be too emphatically told of this danger. In this connection, certain canning methods which are fads spring up from year to year. These methods call for unusual and peculiar rituals of procedure. Women sometimes place too high a value on good appearance and process the foods only very slightly, especially if they wish to enter the food in competition. Unless the method employed in canning has a sound scientific method and sterilization is really effected, the food is a source of potential danger to the family. However, it is true that few pressure canners are being released to the

market now. Women may decide to take a chance on some other method of processing in order to try to save food which they have grown. Food processed by any other method than the steam pressure canner or the pressure cooker should be boiled vigorously for fifteen minutes in a covered pan before serving. Such heat treatment destroys the toxin given off by the Clostridium botulinum organism, although it does not kill the organism itself. Under no circumstances should food so processed be tasted before such heating occurs. One further word of warning concerning the pressure canner itself; the gauge should be checked for accuracy regularly and the canner used according to directions in order that a false sense of security does not arise from its use. When a pressure cooker is not available, it is wise in some cases to consider other methods of food preservation, such as freezing or drying.

Other Spoilages and Health Hazards

There are, of course, other spoilages and health hazards which arise from food which has been poorly home canned. While none of these are likely to be as serious as botulism, still they may cause minor illnesses or, at least, represent an economic waste in loss of the food and the human effort which went into canning it. It must be remembered that food is a perishable substance, and, if it is not properly cared for, micro-organic life will flourish. It will be recalled that it was urged that only a small quantity of food be handled at one time and that the jars of food be in the processing container before a second quantity is started. Let us picture for a moment what happens if the reverse is true. A large quantity of food is washed, peeled if necessary, and allowed to stand in a kitchen which is almost sure to be warm. Enzymatic changes go on rapidly, and micro-organisms grow well on this moist, warm food. If the food does not become actually spoiled, it may become much more inferior in quality as a result of this period of standing around. Eventually, the food may be heated and put into jars, but, if there is a large number of jars, some of them must be held because there is not room for all in the processing vat. Again, there is an almost ideal combination of circumstances for the growth of micro-organisms. The food in the jar will stay warm because the room is warm. Food and moisture are available so that any organisms contaminating the food have almost ideal conditions for development. Final processing in both of these cases might destroy the organisms, but the harm would already have been done in that the food might be sufficiently spoiled to cause some physiologic difficulty. Working with small quantities of food and finishing each lot before going on to the second would eliminate both of these errors.

It is recommended that the jars be cooled as quickly as possible after the processing has been completed in order to eliminate conditions suitable for growth of any organisms which have chanced to remain and to make sure that the quality of the food is improved by not heating any longer than is necessary. This means that jars should not be placed closely adjacent to each other and should never be covered, at this point, with paper, a dish towel, or other material which would insulate them. The jars are placed some distance from each other so that the air may circulate and facilitate cooling.

When the jars are cool, they should be checked after a few days to make sure that the food is keeping. Final storage should be in a cool, dark, dry place. In modern homes it often means that a special place, insulated against the furnace heat, must be provided. Again this makes for discouragement of any micro-organism development.

In the event that the canning process has been improperly performed, certain evidences of spoilage may occur. If the food within the can is frothing and bubbling, if the lid curves upward, if the seal is broken, if there is an outrush of gas when the jar is opened, or if there are unusual odors, then the food should be discarded. To eat or even taste such food might cause food poisoning with attendant physical discomfort and loss of time.

Avoidance of Nutrition Loss

Another factor which needs to be considered as far as these canned foods are concerned is the change in nutritive value which may occur during the process. The house-

wife needs to be informed as to how much she can rely upon these foods to contribute to the daily nutritive needs of the family. Information in this field is often contradictory and incomplete and, for that reason, definite statements concerning the value of canned foods are difficult to make. In general, however, it has been shown that there is a mineral and vitamin loss when vegetables are left in water over long periods of time; hence it is best to wash the food quickly and not allow it to stand in the washing water. Greater quantities of vitamin C are lost after the vegetable or fruit has been peeled or cut and allowed to stand exposed to air. Here we have a second reason for handling only small quantities of food at one time in the canning process. If peeled or cut food stands around, as would be the case in starting large amounts at a time, there is increased nutritive loss. Quick heating of the food immediately after the preliminary treatments of washing and cutting or paring likewise makes for greater retention of vitamin C. Some evidence has accumulated that thiamin is retained well within the food during such treatment. Because there is always some loss of the soluble minerals and vitamins into the cooking water, it should be used in packing the jars. Later, when the food is being served, this liquid should be utilized so that the family gets the greatest possible nutritive value from it. Because long holding of food at warm temperatures seems to reduce vitamin C, quick heating is emphasized. However, if proper procedures are followed in canning vegetables, nutritionally-significant percentages of vitamin C, thiamin, and niacin are retained. Of the B-complex, the loss of thiamin apparently is greater than riboflavin. Obviously, the composition of the raw vegetable or fruit would determine in part the contribution to the diet that one might expect from the canned product. Storage seems not to cause destruction of vitamin A, the amount of thiamin so destroyed is debatable, and during the first months of storage, the loss of vitamin C is significant.

THERE'S A USE FOR EVERY VEGETABLE AND A VEGETABLE FOR EVERY USE

Potatoes and other starchy vegetables are a source of carbohydrates for energy.

Green, leafy vegetables—lettuce, spinach, and others—yield iron, calcium, copper and other much-needed minerals.

Yellow vegetables, such as sweet potatoes, and carrots, offer carotene, from which the body can produce vitamin A.

Tomatoes and cabbage are rich in vitamin C.

The legume vegetables, beans and peas, yield such B-complex vitamins as thiamin, riboflavin, and nicotinic acid.

All vegetables are good sources of most vitamins, and they are all substantially rich in minerals.

SOME OF OUR HEALTH ACHIEVEMENTS IN WISCONSIN

Childhood is safer. More Wisconsin babies live than do European babies.

Over 99 per cent of babies are delivered by physicians. Less than 1 per cent of the babies in Wisconsin are born when a physician is not present.

Since 1910 nineteen years have been added to our average span of life.

Fewer typhoid deaths occur in Wisconsin than in any other state in the nation.

Motherhood is safer. More Wisconsin mothers live to care for their babies than do European mothers.

Many communicable diseases, such as smallpox and diphtheria, have been controlled through scientific efforts and are now classified as medical curiosities.

Appointments to State Public Health Bodies Now Complete

State Board of Health

S. E. GAVIN

WITH the appointment of Stephen E. Gavin, Fond du Lac, as a member of the State Board of Health, Acting Governor Walter S. Goodland has filled all present vacancies in state public health bodies. Dr. Gavin, chairman of the Council of the State Medical Society, was appointed for the term expiring in 1950, and the appointment was unanimously confirmed by the Senate on April 6.

Dr. Gavin has been chairman of the Council of the State Medical Society since 1936. He holds an honorary LL. D. degree from St. Mary's College, Emmitsburg, Maryland, and is a fellow of the American College of Surgeons, a member of the Wisconsin Surgical Club, and a past-president of the State Medical Society as well as of the Fond du Lac County Medical Society. Since 1938, he has been a delegate to the American Medical Association from the State Medical Society. Born in Neenah and graduated from Rush Medical College in 1899, he has practiced medicine and surgery in Wisconsin throughout his medical career, with the exception of his service in World War I in which he participated as a captain and was promoted to the rank of Major in the Medical Corps. He served with the Tank Corps for eight months and later in the general hospital at Fort Sheridan.

Other members of the Board, who were appointed during previous administrations, are Dr. Stephen Cahana, Milwaukee, who has served since 1927; and Dr. Carl W. Eberbach, Milwaukee, who was appointed in 1940. Dr. Cahana received his medical education at the University of Illinois College of Medicine, graduating in 1911. Dr. Eberbach graduated from the University of Michigan Medical School in 1916. The former is assistant clinical professor of medicine and the latter assistant clinical professor of surgery at Marquette University School of Medicine. Appointments earlier announced by the Governor include Dr. A. E. Rector, Appleton, Dr. W. T. Clark, Janesville, Dr. Gunnar Gundersen, La Crosse, and Dr. I. F. Thompson, Racine. An eighth member of the Board by reason of his official position is Dr. C. N. Neupert, State Health Officer.

STEPHEN CAHANA

C. W. EBERBACH

Secretary of the State Board of Medical Examiners

Also of medical importance is the announcement of the election of Dr. C. A. Dawson of River Falls as secretary of the State Board of Medical Examiners. Dr. Dawson has long served the medical profession in the ca-

C. A. DAWSON

pacity of chairman of the Committee on Public Policy of the State Medical Society and has been a member of the State Board of Medical Examiners since 1941. Graduating in 1903 from the University of Minnesota College of Homeopathic Medicine and Surgery, Dr. Dawson set up practice in Wisconsin in 1912 and since that time has faithfully and energetically served the best interests of the profession in this state.

Board of Examiners in the Basic Sciences

The Executive Office has recently announced the reappointments of Professor Robert N. Bauer of Milwaukee and Professor Michael F. Guyer of Madison to the Board of Examiners in the Basic Sciences. Both Professor Bauer and Professor Guyer have been members of the Board for many years and, together with Professor William H. Barber of Ripon, the third member of the Board, have directed the administrative policies involved in the Basic Science Law, which was enacted following its endorsement by the State Medical Society in 1925.

Professor Bauer, professor of inorganic chemistry, undergraduate division, Marquette University, Milwaukee, has been a member of the Board since 1925 and has served as its secretary continuously since his appointment. He holds the degrees of Graduate in Pharmacy and Bachelor of Science.

Professor Guyer, professor of zoology at the University of Wisconsin since 1911, also has been a member of the Board since 1925. He is a fellow of the American Association for the Advancement of Science and holds memberships in many scientific organizations. A graduate of the Universities of Michigan, Nebraska, Chicago, and Missouri, he is the author of "Animal Micrology," "Being Well Born," "Animal Biology," and "Speaking of Man," and has also conducted various technical biologic researches.

Professor Barber, professor of physics at Ripon College since 1906, is a native of Black Earth, Wisconsin. He holds the degrees of Bachelor of Science and Master of Arts. Besides his activities as an educator, he has been active in the municipal affairs of the city of Ripon. His memberships in scientific groups include the American Physical Society and the Wisconsin Academy of Sciences.

ONE HUNDRED SECOND ANNUAL MEETING TO BE HELD IN MILWAUKEE, SEPTEMBER 13, 14, 15

F. D. MURPHY

The scientific program for this year's meeting has been virtually completed. Acceptances have been received from many out-of-state speakers as well as those members of our own Society who have been invited to participate by the Council on Scientific Work through Dr. Francis D. Murphy, who is in charge of this year's scientific program.

Scientific Exhibits

Dr. C. D. Neidhold of Appleton has been selected by the Council on Scientific Work to arrange the scientific exhibits to be presented in the Milwaukee Auditorium this September. A wide variety of scientific exhibits has been obtained by Dr. Neidhold.

Technical Exhibits

Announcement of available exhibit space was released by the Society in early February. Within forty-eight hours of the announcement of the exhibit space, all available booths had been reserved.

Mark your calendar now and make plans to attend the meeting in Milwaukee on September 13, 14, and 15.

The Nation at War

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

The Procurement and Assignment Service For Physicians, Dentists and Veterinarians

Responsibilities, Accomplishments and Future Problems*

By HAROLD S. DIEHL, M. D.**
Minneapolis

The organization of the Procurement and Assignment Service consists of a Directing Board, a Central Office in Washington, a Consultant's office in the headquarters of the American Medical Association in Chicago, and Corps Area and State Committees, with local, county, or district committees serving in an advisory capacity. The physicians on these various boards and committees have given unselfishly and unstintingly of their time and services. Without compensation, at great personal sacrifice, and at times in spite of uninformed or malicious criticism, these men have rendered and are continuing to render an invaluable and patriotic service to our country in its war effort. It is primarily to the chairmen and the members of state and local Procurement and Assignment Service committees that the real credit for the accomplishments of this service belongs.

With the American Medical Association and the various state medical societies, the Procurement and Assignment Service has a most intimate, though unofficial, relationship. In 1940 the American Medical Association at great expense and effort prepared a roster of all the physicians in the United States with detailed information in regard to their training, experience and qualifications. This invaluable roster was made available to the Procurement and Assignment Service immediately after its organization. In addition, the American Medical Association has made its staff and facilities available at all times to aid in the work of the Procurement and Assignment Service. In like manner, state medical societies not only have cooperated wholeheartedly, but in many instances have provided a large portion of the expenses and carried much of the work of the state and local Procurement and Assignment committees. Without this assistance and support, the work of the Procurement and Assignment Service could not possibly have been carried out. To these various medical associations we acknowledge our deep indebtedness.

. . . the Army and the Navy have agreed not to grant commissions to physicians declared essential by the Procurement and Assignment Service for civilian medical care. Likewise, local Selective Service boards have been directed by National Headquarters to secure the recommendation of the Procurement and Assignment Service whenever they are considering the classification of a physician, dentist or veterinarian.

Problems of the Procurement and Assignment Service For 1943

With the advent of 1943, an analysis of the physicians of the country revealed that the statement about our having 180,000 physicians was misleading and that withdrawals from this group were already approaching the limit of the available supply. The figures show that we do have a total of approximately 180,000 physicians registered in the United States. Of these, however, approximately 15,000 occupy full-time positions in public health departments, medical schools, insurance companies, or other governmental

* Excerpts from a paper presented before the War Sessions of the American College of Surgeons, Milwaukee, March, 1943.

** Member, Directing Board, Procurement and Assignment Service; Dean of the Medical Sciences, University of Minnesota.

or private agencies not engaged in the practice of medicine; 28,000 are over 65 years of age, and for planning purposes are counted as only one-third effective by the Procurement and Assignment Service; it is estimated also that approximately 5 per cent, or a total of 7,000, of the physicians under 65 are completely or partially ineffective; 3,000 are resident physicians in hospitals; and approximately 42,000 were in the armed forces on the first of January. This leaves only about 94,500 effective physicians remaining in civilian practice. There are areas in most states which have never had more than one doctor to two, three, or even more thousands of people. We cannot hope to bring about the millenium in these areas during the war when there is an over-all shortage of physicians. On the other hand, in areas in which a shortage of physicians has been created by the war, a ratio of 3,000 or more people per physician is considered by the Directing Board as probably constituting a critical situation. On a basis of this over-all ratio of one physician for 1,500 population, approximately 83,000 physicians are needed to provide essential medical services for the civilian population. This leaves only 11,500 physicians who can be considered as "available" from civilian practice in 1943 to enter the military services. In addition, between 4,000 and 5,000 hospital interns and residents will become available for military service during 1943.

Recruitment For the Armed Forces

On the basis of their established tables of organization, the authorized expansion of the Army and Navy in 1943 would require between 40,000 and 45,000 additional medical officers. In spite of this, both the Surgeon General of the Army and the Surgeon General of the Navy have accepted the above computations as to the number of physicians who can be safely withdrawn from civilian practice. This means that they will have to adjust their plans of organization and operation so as to get along with fewer medical officers than they consider ideal. Both the Army and the Navy, however, are willing to make these adjustments.

. . . Even in those states in which there is an over-all shortage of physicians, there probably are metropolitan areas from which some physicians can and should be released. If other areas within these states are critically short of physicians, efforts should be made to induce some of the available physicians from the metropolitan areas to move into these shortage areas. If they are unwilling to do so, they should be declared available for military service and persuaded to apply for commissions.

Recruitment Procedure

The Procurement and Assignment Service proposed, and the Army agreed, that recruitment in 1943 should be done by the Procurement and Assignment Service instead of by Army recruiting teams. Briefly summarized, the procedure agreed upon is as follows: The State Chairmen submit monthly lists of available physicians to the Central Office. From this office letters are sent to these physicians requesting them to apply for commissions and enclosing cards addressed to the State Chairmen indicating their preference for Army, Navy, or Air Corps service. The names of those choosing Army service are sent to the nearest Army Officer Procurement Board, which supplies the necessary application forms and authorizes physical examinations. A similar procedure is followed for those who prefer to serve in the Navy. In case a physician does not apply for a commission when requested to do so, it is the responsibility of the Procurement and Assignment Service, in cooperation with the local medical society, to induce him to accept the assignment which he has been given.

Some predict that it will be difficult to secure the number of physicians agreed upon for the armed forces in 1943. They point out that most of those who really want to serve are already in service. This is doubtlessly correct, but we feel certain that many more physicians will be willing to go when they are told specifically and individually that their services are needed. For others some persuasion may be necessary. As a whole, the medical profession has responded magnificently to our country's call. It is but a very small minority who would place selfish interests above professional and patriotic responsibilities.

Quoting a statement which Dean Thorald Sollmann of Western Reserve University made to a recent graduating class in his medical school: "The time has come when it doesn't matter much that someone else evades his obligation. Each must live with his own conscience; and he who has none is missing something. Patriotism is what you give, not what you get; and what *you* give, not what the other fellow gives or withholds. And if it should turn out, as it may in a topsy turvy world, that he gets the plums and you get the husks, well—, a good doctor can lead a useful and satisfying life anywhere and anytime without plums."

Conclusion

As the representative of the Directing Board of the Procurement and Assignment Service, I welcome the opportunity this occasion has provided to summarize briefly these major problems which confront each and everyone of us in the medical profession in the critical times remaining before our country can emerge victorious in the titanic struggle in which we are engaged. In meeting such responsibilities, the medical profession has always done its full share, and we are confident that, come what may, the physicians of this country can be depended upon to do their share and more in meeting their problems and responsibilities.

Medical Circular No. 3

National Headquarters of Selective Service has issued under date of February 15, 1943, "Medical Circular No. 3," which is introduced by the following statement from Lewis B. Hershey, Director:

The purpose of this circular is to guide physicians and dentists in the preliminary physical examination of registrants *to the end that all selectees will be physically examined and processed locally in like manner.* The following pages furnish the reasons for the adoption of the present system of examination by Selective Service, the instructions covering the preliminary physical examination, section 623.33 (revised) of the regulations, and revised List of Defects (DSS Form 220). It is hoped that each examining physician and dentist will study carefully his personal copy of the circular—familiarize himself thoroughly with the details of the examination, as well as with the lists, and then adhere rigidly to the regulations. The objective is to disqualify all registrants locally who have manifestly disqualifying defects and forward all qualified registrants to the examining and induction station.

This Medical Circular No. 3 affords the welcomed opportunity to express to the examining physicians and dentists of the Selective Service System, the appreciation of this Headquarters for their loyal and valuable professional service which has proved of the utmost importance in helping the Nation to meet its wartime needs.

LEWIS B. HERSHEY,
Director.

It is of utmost importance that local examining physicians and dentists adhere strictly to the regulations set forth in the circular and that they indicate physical defects exactly as set forth under the "List of Defects." This is of extreme importance in that it will save much correspondence between State Headquarters and local boards and between National Headquarters and State Headquarters. For example, it is not sufficient to say merely that an examinee has a heart ailment. Rather it must be stated: "Heart, dilatation or hypertrophy of, evidenced by displacement of the apex impulse to the left of the midclavicular line or below the sixth rib."

The following, quoted directly from the circular, emphasizes the fact that every examining physician and dentist should become thoroughly familiar with "Medical Circular No. 3":

The purpose of the Selective Service physical examination of registrants is to dispose of locally and classify into IV–F all registrants manifestly unfit for military service, thereby saving the time of such unfit registrants, the expense incident to travel, and the time of the physicians and dentists at the joint induction stations.

The character of the Selective Service physical examination was changed from a complete medical examination to a preliminary physical examination because of the great increase in manpower needed by the armed forces, because of accruing shortage of physicians, and because final authority for physical examination is vested with the armed forces. Now additional demands are being placed on local boards and examining physicians through the discontinuance of recruitment. Executive Order No. 9279, dated December 5, 1942, and LBM No. 178 route through Selective Service channels all men between 18 and 38 years of age who enter the armed forces.

It seems timely to call attention to the present regulations dealing with the character of the ex-

amination and to the occasional mistakes on the part of the local board examining physicians which have been due largely to failure to adhere strictly to the regulations. In some instances registrants have been forwarded to recruiting and induction stations with only one leg, with a draining urinary fistula, or with marked deformities of advanced Pott's Disease.

Several of these cases were photographed and the pictures forwarded to the War Department constituting incontrovertible evidence that Selective Service Regulations were not followed in these instances and that the registrants had not been examined *in the nude* and *in action*. The preliminary physical examination will not be effective unless the registrant is examined in the nude (stripped of all clothing), as prescribed, and unless the regulations which apply to the physical examination are rigidly followed (sec. 623.33).

Inspection of the oral cavity is still an integral part of the physical examination. Its purpose is to disclose dento-oral defects which would manifestly disqualify a registrant for military or naval service, as specified in DSS Form 220. As a matter of clinical and statistical interest as to whether or not the registrant is acceptable, the examining physician or dentist should record any unusual anomalies or any pathological lesions observed during the examination.

The preliminary physical examination as outlined in the Selective Service Regulations *should be given only by a physician*. Unfortunately, some have erroneously contended that, because it consists solely of inspection, this examination may be given just as effectively by a lay member of the local board and that it does not call for the professional judgment of a physician. This attitude, no doubt, is partially responsible for the mistakes that have been committed. However, it should be obvious that only a physician is capable of understanding the medical terminology involved in DSS Form 220; that only a physician can supply the professional judgment called for in DSS Form 220; and that only a physician, through a careful and rigid inspection, is capable of determining the existence of many of the physical defects, deficiencies, disorders, and diseases listed in DSS Form 220.

The very adoption of this preliminary physical examination reflects the great confidence of Selective Service in its examining physicians. *Enthusiastic acceptance by the examining physicians is essential to the success of this program*—enthusiasm such as is reflected in the following excerpt from a letter of one of our Selective Service examining physicians, who writes the following:

"Many of the examining physicians who are members of my Board of Examining Physicians * * * and who have in their practice of modern, streamlined medicine, allowed the 'inspection' phase of physical examination to be supplanted by the X-ray and other laboratory diagnostic measures, are beginning to develop their skill of diagnosing defects * * * by an ever improving inspection ability. My examining physicians, participating in this present screening type of physical examination, have become enthusiastic in playing the game of 'spotting' pathology. Examining physicians who are really interested in this type of examination owe a debt for the privilege of participating in this refresher course which is making them more alert and is developing their senses of sight, hearing, and touch in the detection of physical defects."

To meet the present needs, Selective Service has revised the regulations, pertaining to this preliminary physical examination, and the List of Defects. In addition, Selective Service has listed in DSS Form 220 those defects, deficiencies, disorders, and diseases which, though not manifest in character, do nevertheless disqualify registrants, if properly certified by affidavit filed as prescribed in section 623.33 of the Selective Service Regulations. However, *the character of the physical examination remains unchanged.*

The three requisites to complete success of this preliminary physical examination are—

1—Enthusiastic acceptance of the program.
2—Thorough familiarity with the revised regulations, section 623.33, and with the revised List of Defects (DSS Form 220).
3—Strict adherence to the regulations.

Military Notes

Lieutenant Commander James W. MacGregor, formerly of Portage, is at present assigned to the Naval Air Station at San Diego, California. In a recent letter, he writes: "I reported out here for duty on January 18 and like both the Navy and California immensely. Until two weeks ago, I was stationed at the Dispensary in charge of the Isolation Hospital. Since March 11, I have been at the Family Hospital doing diagnosis and internal medicine. The Family Hospital takes care of all dependents of Naval and Marine personnel in the San Diego area. We have quite a busy service—especially outpatient."

He mentions two other Wisconsin doctors now in service. **Lieutenant Commander R. B. Dryer**, formerly of Madison, has reported for duty at San Francisco. **Lieutenant Commander John B. Wear**, also formerly of Madison, had been called for consultation to the Family Hospital where Lieutenant Commander MacGregor is located. Lieutenant Commander Wear is located at the Naval Hospital of the Naval Air Station, San Diego.

—△—

Lieutenant Commander Chalmer Davee, whose home town is River Falls, is now on active duty with the Navy at Great Lakes. He began his service on April 19.

—△—

Lieutenant David J. Twohig, who entered the service October 22, 1942, and received his training at Carlyle Barracks, Pennsylvania, is on duty in

England as Assistant Evacuation Officer for the United Kingdom. He reports that **Colonel W. S. Middleton**, formerly of Madison, is in the same office. Lieutenant Twohig states that much of his work consists of traveling about England to the various hospitals. He was formerly of Fond du Lac.

For "personal gallantry" in caring for the wounded while under enemy fire, **Major Archie H. Tax**, formerly of Milwaukee, is the receiver of the silver star award of valor. The citation has been received by Mrs. Tax, who is now in Menomonee Falls.

Major Tax is a regimental surgeon of an armored unit in Tunisia. On February 15, the citation reports, while enemy planes bombed and strafed one of the companies in Major Tax's unit, he went out to a vehicle which had been hit and had burst into flames. With complete disregard for his own safety, while the ammunition in the burning vehicle was exploding and the area was under hostile artillery fire, he administered first aid to several wounded soldiers and then evacuated them to the rear.

Captain W. C. Finn, of Fond du Lac, is at Camp Rucker, Alabama, at the 164th Station Hospital and is enjoying his new assignment. He was transferred to Camp Rucker from Sheppard Field.

—△—

Lieutenant Stephan Konz, formerly of Appleton and now of the Army School of Roentgenology at Memphis, Tennessee, intimates that not only he but also many of his class associates from all parts of the United States enjoy the periodic news letter sent him. Lieutenant Konz is regularly stationed at Camp Grant, Illinois, and has by this time completed his six weeks intensive course at Memphis.

—△—

From the Army Air Forces Advanced Flying School at Moody Field, Georgia, comes word from **Major Leo R. Weinshel**, former Milwaukee physician that *The Journal* reaches him regularly and that he reads it from cover to cover.

As Chief of Surgical Service and Executive Officer of the Station Hospital, he finds his work both interesting and enjoyable. He writes: "We have set up a unique type of Burn Room at our hospital which has received special commendation from the Inspector General of the Army Air Forces Southeast Training Center and from Lieutenant Colonel R. A. Griswold, Surgical Consultant, Services of Supply, of the Fourth Service Command, who recommended that this particular type of Burn Room be instituted at other Air Force stations and Armored Force stations for the treatment of acute burns."

—△—

Writing from the Caribbean Area, where he has been located since January, 1941, **Lieutenant Colonel C. S. Williamson**, Green Bay, also expresses appreciation for the "news letter." Formerly assigned as surgeon at one of the Air Corps hospitals, he is now the Area Surgeon for the Air Corps and, as such, must travel by air over a large section of the Caribbean. He states that their medical problems are largely limited to those of malarial control, venereal disease control, and the treatment of traumatic injuries associated with accidents.

Lieutenant Williamson finds the region delightful in many respects and makes particular mention of the climate, which he compares with that "about which Florida and California talk so glibly, not too hot nor too cold."

—△—

Captain D. M. Britton, formerly of Madison, is still located at the Station Hospital of the Portland Army Air Base, Portland, Oregon, where he has been since he entered the Army in July, 1942.

A recent direct short wave broadcast from Tokio, Japan, indicates that **Captain William N. Donovan**, Madison, who was captured by the Japanese at either the fall of Bataan or Corregidor, is alive and well. Captain Donovan's message stated that he was being well treated and that his family should not worry about him.

Captain Donovan was awarded the distinguished service cross for his heroism in the defense of the Philippines and, in 1942, was recognized as the young Madison man who contributed the greatest service to the community during that year.

DATES SET FOR ONE HUNDRED SECOND ANNUAL MEETING

The One Hundred Second Annual Meeting of the Society will be held in Milwaukee on September 13, 14, and 15. Mark your calendar now. Make your plans to attend.

RUSSELL M. KURTEN, M. D.
President, State Medical Society of Wisconsin

Dr. Russell M. Kurten, Racine, the new president of the State Medical Society of Wisconsin, was born at Racine in 1899. He received his preliminary education at Racine High School, St. Thomas College, St. Paul, and Marquette University. He was graduated from the Marquette University School of Medicine in 1924.

Dr. Kurten has practiced at Racine since his graduation from medical school. He is a member of the American College of Surgeons and has a certificate of the American Board of Surgery. He was twice speaker of the House of Delegates of the State Medical Society.

. . . . THE PRESIDENT'S PAGE . . . .

A Challenge to Leadership

FATE decreed that Frank E. Butler was not to be permitted to fill out his tenure of office as president of the State Medical Society of Wisconsin. From the start he knew that the odds were against him. Despite the handicaps of pain and suffering and waning strength, he fought through the annual meeting at which he was inaugurated into office. He continued his fight in the interest of our Society until a kind Providence brought him relief. He had accepted the challenge with the knowledge that he might not see the fulfillment of his task. To the end he never quit trying.

Under our Constitution and By-Laws, it devolves upon the president-elect to take over immediately after the death of the president.

On the one hand, Russell M. Kurten will be deprived of the fanfare associated with the installation. The long-range planning developed during the year as president-elect will be cut short so that the program of the incoming president, to which every one looks forward with keen anticipation, may under the changed circumstances become an anticlimax. On the other hand, our president is inheriting a "going concern." Great strides have been made recently in several fields of importance. For example, the newly developed industrial health program of education which started so auspiciously with the conference in Milwaukee last November has been carried to the profession in two more centers this spring and has in a measure replaced the usual spring clinics. With the experience of the Milwaukee meeting, the sessions in Madison and Appleton just completed were everything early promises predicted.

During the last few years there has been increasing evidence that the organized profession of medicine in Wisconsin has been growing closer to and has been cooperating more actively with two important branches of state government; namely, the Board of Medical Examiners and the Board of Health. Recent appointments to these agencies have been of men who have, by their past records, shown themselves to be keenly concerned with matters of public health from the point of view of organized medicine. The State Society is now actively engaged in the sponsorship and enactment of the reregistration bill, which should strengthen immeasurably the enforcement of the Medical Practice Act by the Board of Medical Examiners. The enactment of this law at this session of the legislature is of utmost importance.

It should be the aim and ambition of the State Medical Society to walk arm in arm with these two boards toward the goal of greater health achievements for Wisconsin. It appears now as though we are about to see the greatest cooperation between these various groups that we have seen in many years.

At this particular time the duties falling upon our new president are necessarily increased by reason of the legislative session. At a moment's notice matters of vital importance are brought to focus by a sudden and unexpected turn of events. These matters require immediate attention by the executive officers of the Society. The Society is particularly fortunate in having selected at its last meeting Russell M. Kurten to follow in the footsteps of Frank Butler. Our president brings to his task a background of experience in Society affairs ranging from committee work to several times speaker of its House of Delegates. He is intimately familiar with the many details of Society activities. He is young, ambitious, forceful, enthusiastic and levelheaded. Upon his broad and able shoulders the task ahead should be easy. Russell Kurten is eminently qualified to accept the challenge. I am sure I voice the unanimous sentiment of our membership in wishing him every success in his new assignment.

—GUNNAR GUNDERSEN, *Past-President.*

THE WISCONSIN MEDICAL JOURNAL

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« « « EDITORIAL » » »

A Glance Ahead

BY THE time this *Journal* is in the mail, the curtain will have been rung down on two more outstanding services of the Society. The Industrial Postgraduate Clinics at Madison and Appleton will have been concluded successfully, we are confident. The supplement to the April *Journal*—Extra Ration Points for Special Diets—will have been widely distributed—probably upwards of six or seven thousand copies.

In this issue there appears the special article dealing with Home Canning, and reprints are available at nominal cost for distribution to patients and friends who seek the advice of their medical acquaintances.

There are other projects ahead. Physician members of the Society accept as matter of fact the scientific information contained in *The Journal*, the programs planned for the annual meeting, the activities of their scientific committees and other groups within the structure of the Society that constitute its vital "organs." But in addition to these activities, there is much of new and important need that is contemplated. Further efforts are being directed to the perfection of medical participation in the civilian defense activities; under its responsibilities to the Procurement and Assignment Service, the Society has prepared and is maintaining a current inventory of physicians in all counties of the state.

More?—Yes, and much. The columns of *The Journal*, it would seem, can also serve the physicians by expanding gradually its editorial policies to include succinct statements relative to various current matters. Along this line, it has become the policy of *The Journal* to prepare periodic columns on trade news of especial physician interest—the newer devices and agencies in the field of treating the sick. So also appears the column "News of the Neighbors" that members may be acquainted with the activities of other state organizations.

These are all illustrative only—but in a double sense. They are illustrative of what is being done and, above all, of the importance of maintaining an intimate contact with that program through *The Journal*. It is not just another magazine—it is not alone scientific—it is the house organ of the profession in Wisconsin.

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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Mrs. O. M. Layton, Fond du Lac, President-Elect
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Public Relations

MRS. R. D. CHAMPNEY
Milwaukee

TO BE very certain of the importance of our work in public relations, we need only to consult the constitution of the Woman's Auxiliary to the State Medical Society of Wisconsin. There we find that the first object of the State Auxiliary is "to extend the aims of the medical profession to all organizations which are interested in the improvement of public health and the advancement of health education." This covers a wide field.

Looking further, we find that object number three in our constitution is "to cooperate with the State Medical Society of Wisconsin in the promotion of public health and social welfare." The members of the medical profession look to us to act as a liaison group between them and the lay public.

The ways in which we can fulfill this mission are many. They are dependent upon the needs of the individual communities. In order to be most effective in our public relations work we must first prepare ourselves. A poll of public opinion among doctors throughout the country brought the following suggestions as to how the public relations department might best serve the profession: "Study the A.M.A. platform; know your speakers' bureau; familiarize yourselves with available materials for health education; understand the problems of the profession." We must educate ourselves before we attempt to educate anyone else.

If your county medical society has a speakers' bureau, give this project your full cooperation in contacting lay organizations and placing speakers before them. Speakers are available from the Bureau of Health Education of the A.M.A., of which Dr. W. W. Bauer is the director. Because of the increased amount of work and the difficulties of transportation occasioned by the present emergency, Dr. Bauer asks that at least three speeches to groups of several hundred be arranged in the community. If this is not possible, in lieu of a speaker the Bureau of Health Education will supply you, on request, with a packet on a topic of health education, from which you may prepare a talk of your own. Interview scripts and dramatized programs suitable for broadcasting over local radio stations may also be obtained from the bureau. These are available for use in projects approved by your local medical society. Another service of the Bureau which may be helpful to you is the *Hygeia* clipping loan collection service. The Bureau has assembled *Hygeia* articles and clippings on approximately seventy-five popular health topics, many of which are accompanied by outlines for proposed talks to be developed from the clipping material. These loan collections may be borrowed for ten days from the Bureau of Health Education, 535 North Dearborn Avenue, Chicago. *Hygeia*, incidentally, is an excellent avenue

for public relations work. Help to have it placed in every possible home and school.

Much of our work in public relations can be carried on in our everyday contact with lay people. We are making a contribution to this effort when we actively participate in the work of other clubs. At the present time, with the abundance of war work to be done, the opportunity is greater than ever.

I urge you to cooperate with the Red Cross in furthering its program of classes in nutrition and home nursing, as well as the work of production. Take an active part in the campaign of the Women's Field Army for the Control of Cancer. Help with the Summer Roundup of Pre-school Children, sponsored by the P.T.A. Endeavor to assist other organizations wherever possible. We can, as individuals, accomplish a good deal in helping to "extend the aims of the medical profession" to other organizations.

If you are not already a fan of the A.M.A.'s radio dramatization, "Doctors At War," make it a point to listen to it next Saturday over the NBC network. It is broadcast at 4:00 p. m. and again by transcription at 8:00 p. m. This is an excellent program, having the official sponsorship of the Medical Corps of the United States Army and the United States Navy. Once you listen to it, I'm sure you will be wholeheartedly in favor of it and will do your best to popularize the program among others.

The work of the Public Relations Committee can be promoted most effectively only if each Auxiliary member considers herself a unit of that committee, actively participating in organizations interested in the promotion of better health and endeavoring to carry the aims of the medical profession to those with whom she comes in daily contact.

County Auxiliary Proceedings

Dane

Members of the Woman's Auxiliary to the Dane County Medical Society met for luncheon at the home of Mrs. L. V. Sprague, Madison, on April 12. Mrs. A. A. Quisling, chairman of the hostesses, was assisted by Mrs. W. B. Dimond, Mrs. L. E. Holmgren and Mrs. J. T. F. Gallagher.

Douglas

At a luncheon meeting at Superior on April 6, the Woman's Auxiliary to the Douglas County Medical Society voted to hold but one meeting a year for the duration of the war. However, members will make surgical dressings each Wednesday afternoon.

Mrs. C. W. Giesen, Superior, was elected president of this auxiliary, and Mrs. E. A. Myers was chosen secretary-treasurer and press chairman.

Fond du Lac

Mrs. P. G. McCabe, Mrs. D. N. Walters, and Mrs. P. J. Clark were named on the nominating committee at a dinner meeting of the Fond du Lac County Medical Auxiliary held at the Hotel Retlaw on March 25. Action was taken at this meeting to make a financial contribution to Truax Field, Madison.

During the program, Miss Hattie Cooper discussed "Nutrition," and Mrs. J. S. Huebner reviewed the book "The Making of a Surgeon" by Dr. E. V. Smith.

La Crosse

Thirty members and five guests of the La Crosse County Medical Auxiliary met at the home of Mrs. J. C. Fox, La Crosse, on March 31. A quiz on isolationism was presented by Mrs. Gunnar Gundersen. Mrs. J. R. Richter of Chaseburg entertained with several readings. The program was arranged by Mrs. E. E. Seedorf.

Mrs. R. E. Flynn, a member of the nominating committee, offered the following slate of officers:

President—Mrs. J. C. Fox, La Crosse
President-elect—Mrs. G. D. Reay, Onalaska
Secretary-Treasurer—Mrs. J. F. Eagan, La Crosse

Hostesses with Mrs. Fox were Mmes. C. L. Mears, C. J. Moran, J. E. McLoone, E. J. Schneeberger, R. C. Johnston, E. E. Seedorf, Martin Sivertson, and Gunnar Gundersen.

Milwaukee

Once a year the Woman's Auxiliary to the Medical Society of Milwaukee County has a mother and daughter meeting. This was held in the ballroom of the Wisconsin Hotel, Milwaukee, on April 9. Many members brought their mothers to have lunch with them and to listen to a most interesting program.

Guest speaker at this meeting was Mrs. Frances Bruce Strain of Evanston, Illinois, who is widely known as a writer and speaker on social hygiene. Using as her title: "The Horizon of Youth in War Time," Mrs. Strain said that helping youth find the real answers to its problems will do more to stem the rising flood of delinquency than strong-arm methods of coercion.

"Delinquents aren't a special class of youth, they are just children who have made mistakes," she declared. "They need sympathetic understanding of

their very desperate needs and guidance in attaining them. Whether it's right or wrong, we have raised American girls and boys to think for themselves, be independent. They will resent force as a panicky attempt at repression by adults and the resulting antagonism will create a greater breach."

Mrs. Strain urged the creation of recreational centers for junior and senior high school youths, and a consistent program of social activities for them, as well as for men in the armed forces. She cited three dominating desires of youth which, if fulfilled, would remove delinquency: The need for personal achievement, especially a form of economic independence through a job; the need for social participation in a group; and the need for dating members of the opposite sex. "Answer these needs and there will be no necessity for curfew laws and increased police forces," she said.

Assisting the Women's Field Army for the Control of Cancer, the Milwaukee County Auxiliary is actively engaged in a campaign to educate the public in recognizing early symptoms of the disease and seeking treatment. Working also with the Medical Society of Milwaukee County, the auxiliary sends out speakers to give five-minute talks before lay organizations on this subject. Mrs. H. O. Zurheide, president, called upon Mrs. Wright for her cancer talk, which she will also give to other groups.

In charge of this meeting were Mmes. E. L. Everts, E. F. Guy and D. D. Frawley.

Outagamie

On March 18, the Woman's Auxiliary to the Outagamie County Medical Society held a supper meeting at the home of Mrs. G. W. Carlson, Appleton. Bridge was played following the business meeting, with Mrs. R. T. McCarty winning first prize.

Mrs. Carlson was assisted by Mmes. Charles Reinick, E. J. Zeiss, F. J. Rankin, C. A. Pardee, and F. J. Huberty.

Waukesha

Three new members were welcomed at a meeting of the Woman's Auxiliary to the Waukesha County Medical Society which was held at the Majestic Hotel, Oconomowoc, on April 7. They are Mrs. D. H. Lando, Mrs. F. G. Zietlow, and Mrs. G. W. Lawler, all of Waukesha.

A report of the state board meeting, held in Milwaukee in January, was given by Mrs. E. L. Lochen, auxiliary president.

When the business meeting was adjourned, the program was turned over to Mrs. W. H. Oatway, who gave a very interesting talk on "Quilts—Yesterday, Today and Tomorrow." Tracing the history of quilts through the centuries, she pointed out that the oldest pattern known is the "Crazy Quilt."

Following her talk, Mrs. Oatway displayed two exquisite quilts which had been loaned by Mrs. W. T. Murphy, an auxiliary member. Also shown were quilt blocks furnished by women in Taycheedah, whom Mrs. Otaway had interested in the work.

Winnebago

Mrs. Karl Koehler, Neenah, was guest speaker at a meeting of the Winnebago County Medical Auxiliary on the evening of April 1 at the home of Mrs. G. E. Forkin, Menasha. Her subject was "Antiques in Furniture and Glassware." A dinner at the Valley Inn preceded the business meeting and program.

When their own meeting was concluded, members of the Winnebago County Medical Society joined their wives at the Forkin home for a social evening.

Society Proceedings

Brown—Kewaunee—Door

When the Brown–Kewaunee–Door County Medical Society held a dinner meeting at the Beaumont Hotel, Green Bay, on April 8, Dr. Frederick W. Madison, associate professor of medicine of the Marquette University School of Medicine, Milwaukee, gave an illustrated talk on "Hemorrhagic Disease."

Dane

Dr. Eben J. Carey, dean of the Marquette University School of Medicine, Milwaukee, spoke on "Motor Nerve Endings in Health and Disease" at a meeting of the Dane County Medical Society on Tuesday, April 13, at the Madison, Club, Madison. Prior to the meeting, the board of trustees convened.

Dodge

On March 25 at 7:00 p. m., the Dodge County Medical Society held a dinner meeting at Hotel Rogers, Beaver Dam, with the wives of the physicians as guests. Scientific films on "Sulfonamides" and "Pneumonia" were shown.

Douglas

The Douglas County Medical Society met at Hotel Superior, Superior, on April 7, at 6:30 p. m. The program consisted of a symposium on "Sulfonamides" presented by the following Superior physicians: Dr. Henry A. Sincock, Dr. James W. McGill, Dr. Herbert J. Orchard, Dr. Thomas J. Doyle, and Dr. C. W. Giesen.

Eau Claire—Dunn—Pepin

At a dinner meeting of the Eau Claire–Dunn–Pepin County Medical Society on Monday, March 29, at the Hotel Eau Claire, an audience of forty physicians heard Dr. Lawrence O. Doyle, Minneapo-

(Continued on page 544)

Rogers Memorial Prize Essay Contest

FOUNDED BY

The Rogers Memorial Sanitarium

SPONSORED BY

The Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine and the Rogers Memorial Sanitarium offer prizes of $200 and $100 for the two most meritorious studies in the fields of neurology, psychiatry and psychosomatic medicine.

Eligibility—The contest is open to all members of the medical profession who are citizens of the State of Wisconsin whether they are actually in residence or not and to those who, not ordinarily residents of the state, are stationed in Wisconsin in the Armed Forces.

Time—All papers must be submitted in triplicate and double spaced to the office of the Academy of Medicine, 561 North 15th Street, Milwaukee, Wisconsin, not later than October 1, 1943.

Awards will be determined by judges selected by the Committee and will be presented at the December meeting of the Academy at which time one or both papers will be read. Prize winning papers must be placed on file in the library of the Rogers Memorial Sanitarium but may be submitted for publication (with proper acknowledgment) at the discretion of the author, or the Rogers Memorial Sanitarium.

The Committee reserves the right to withhold the awarding of the prizes if in its judgment no papers worthy of award have been submitted.

Horace Manchester Brown Memorial Prize Essay Contest

SPONSORED BY THE

Milwaukee Academy of Medicine

The Milwaukee Academy of Medicine offers two prizes of $100 and $50 for the two best scientific essays in any field of medicine, surgery or the allied specialties. The essays need not represent original investigation but must not have been previously published. There are no restrictions on subsequent publication.

Eligibility—The contest is open to all physicians who have graduated from medical school later than June, 1933, and who are residing in the State of Wisconsin or who are in the armed forces at the time the essay is submitted.

Time—All essays are to be submitted to the office of the Academy of Medicine, 561 North 15th Street, Milwaukee, Wisconsin, not later than December 1, 1943. They are to be submitted in triplicate and are to be double spaced.

Awards will be determined by judges selected by the Committee and will be presented at the Annual Meeting of the Academy of Medicine. Winning essays will be read at subsequent Academy meetings.

The Committee reserves the right to withhold the awarding of the prizes if in its judgment no essays worthy of award have been submitted.

SOCIETY PROCEEDINGS—Continued

lis, present a series of surgical cases. Assisting him in the discussion were Dr. Chauncey N. Borman, roentgenologist, and Dr. Theodor E. Bratrud, pathologist, both of St. Mary's Hospital, Minneapolis.

At their April meeting on April 27 at the Hotel Eau Claire, the Society heard a discussion on "The Prevention of Tuberculosis Among Doctors and Nurses" by Dr. Arthur A. Pleyte, Milwaukee.

Kenosha

Twenty-four members attended the March dinner meeting of the Kenosha County Medical Society held at the Elks Club, Kenosha, on March 18. Dr. Mynie G. Peterman, Milwaukee, presented a discussion of "The Clinical Value of Electroencephalographs in Diagnosis."

The Kenosha County Medical Society is encouraging its doctors in service to write to their county society about their work in the service. A letter received from Lieutenant Clifford M. Creswell, formerly of Kenosha and now in the service of the Navy, was read at this meeting.

La Crosse

"Some Aspects of Tuberculosis" was the subject of the paper presented by Dr. Jay A. Myers, Minneapolis, at the March 16 meeting of the La Crosse County Medical Society at the Stoddard Hotel, La Crosse.

Marathon

At its dinner meeting on March 3 at the Hotel Wausau, Wausau, the Marathon County Medical Society inaugurated a new plan whereby the group will provide its own program instead of depending on outside talent. This is done in consideration of the problem of transportation and the shortage of physician-speakers.

During a round-table discussion on medical problems, Dr. Joseph F. Smith, Wausau, related various experiences in surgery; Dr. Verne E. Eastman, Wausau, told of his experiences in focal infections; Dr. Harold H. Fechtner, Wausau, discussed recent advances in the treatment of heart disease; and Dr. Otis M. Wilson, Wausau, reported on bills that are pending in the State Legislature which relate to the medical profession.

Outagamie

The Outagamie County Medical Society met at 6:30 p. m. Thursday, April 15, at the Conway Hotel, Appleton. The speaker was Dr. Marshall W. Meyer, Green Bay, district health officer of the State Board of Health. Dr. Meyer spoke on "Contagious Diseases."

Polk

The Polk County Medical Society and the Medical Auxiliary were entertained at the December meeting of the Society by Dr. Walter C. Andrews and his mother and Dr. and Mrs. Raymond G. Arveson, Frederic. Dinner was served in the Parish Hall of the Methodist Church, Frederic. Following the dinner, the group met at the home of Dr. and Mrs. Arveson, where a seasonal program was presented. Thirteen members of the Society and fourteen members of the Auxiliary were in attendance.

At its January meeting, the members of the Polk County Medical Society were guests of Dr. Irl L. Waterman, Amery, at the Amery Hotel. A business meeting was held following the dinner. During the scientific portion of the program, Dr. Waterman gave case histories of patients with different kidney lesions and those of patients with prostatic trouble. A general discussion based on this talk was carried on by the members and centered upon the treatment of each case presented. Dr. Valentine C. Kremser, Amery, gave a brief report of a case of twin pregnancy. Thirteen members were present.

On February 18, the Society and Auxiliary were the dinner guests of Dr. and Mrs. Henry J. Jeronimus, Osceola, at the Methodist Church parlors, Osceola. Following a business meeting, a scientific program was given under the direction of Dr. Jeronimus. Case histories were presented, and the following cases were discussed:

1. Cervical rib.
2. Probable pneumonia, followed by an abscess of the hip with a destruction of the acetabulum and the head of the femur.
3. Thymic death.

Portage

On April 6, the Portage County Medical Society met at the Whiting Hotel, Stevens Point. Seventeen members and guests heard talks presented by Dr. Karl Doege, Marshfield, and Dr. Roy P. Potter, Marshfield, Dr. Doege spoke on "Peptic Ulcer," and Dr. Potter on "X-Ray Diagnosis of Peptic Ulcer."

Racine

The regular meeting of the Racine County Medical Society was held on Thursday, April 15, at 8:15 p. m. at St. Luke's Hospital Library. In connection with the presentation of a sound movie on "The Physiology of Anoxia," the following clinical discussions were presented by members of the Society:

Anoxaemia in Surgery—Dr. Edward W. Schacht, Racine.

Anoxaemia in Obstetrics—Dr. Walter C. Roth, Racine.

Anoxaemia in Pediatrics—Dr. John C. Docter, Racine.

Anoxaemia in Medicine—Dr. Robert S. Wright, Racine.

Rock

The Rock County Medical Society held a meeting on February 23 at the Hotel Monterey, Janesville. "Preventive Aspects of Behavior Problems in Chil-

dren" was discussed by Dr. H. Kent Tenney, Jr., Madison. Thirty-four members attended the meeting.

The February meeting of the Society was held at the Hotel Hilton, Beloit, on March 23. The speaker, Dr. Albert C. Schmidt, Milwaukee, talked on "Fractures of the Forearm." Twenty-four members were present.

Sheboygan

Two discussions featured the March meeting of the Sheboygan County Medical Society at the Sheboygan Memorial Hospital on March 25. "The Present Method of Induction of Doctors into the Armed Forces" was the subject of the talk given by Dr. Robert E. Fitzgerald, Milwaukee. "The Use of the Sterilamp in the Operating Room and Nursery" was presented in a talk given by Dr. John H. Terhorst, Milwaukee.

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society held its March meeting at the MacCornack Clinic, Whitehall, on March 25. Films on "Uses of Sulfonamide Drugs" and "Treatment of Asphyxia Neonatorum" were shown.

At its April meeting on April 15 at Arcadia, the Society had as its guest speakers two representatives of the medical profession in the armed forces; namely, Major Benedict R. Walske, formerly of Independence and now of the Medical Corps Station Hospital, Camp Grant; and Captain Bernard C. Dockendorf, formerly of Arcadia and now of the Medical Corps Station Hospital, Camp McCoy. Major Walske's speech on "Surgical Problems of the Military Surgeon" was followed by a discussion led by Captain Dockendorf.

Washington—Ozaukee

On Thursday, March 25, at the Club Forest, Theinsville, the Washington–Ozaukee County Medical Society held its monthly meeting. Motion pictures on "Eclampsia" were shown.

Winnebago

Marked by an excellent attendance, the regular Winnebago County Medical Society dinner meeting was held April 1 at the Valley Inn, Neenah, with a business meeting and scientific program held later in the evening at the Theda Clark Memorial Hospital. Guest speakers were Dr. H. M. Coon, superintendent of the Wisconsin General Hospital, Madison, and Dr. Karver L. Puestow, formerly of Oshkosh and now of the Wisconsin General Hospital.

Dr. Coon spoke on regulations governing admissions to Wisconsin General Hospital. He pointed out that primarily and basically it is the teaching hospital of the University of Wisconsin Medical School and that only with the cooperation of the members of the medical profession throughout the state can misunderstandings about methods of admission to the hospital be corrected.

With the cooperation of a patient, Dr. Puestow demonstrated the use of the gastroscope. He discussed the importance of this instrument in diagnosis of stomach disorders and pointed out that a more extensive examination was possible with the gastroscope than with roentgen rays.

One of the guests, Lieutenant Emile A. Houle, now stationed at Oshkosh State Teachers College in connection with the training of aviation cadets, spoke on medical problems peculiar to the war. Lieutenant Houle was a practicing physician and surgeon in Massachusetts before enlisting in the Army Air Corps.

Wood

At the annual meeting of the Wood County Medical Society held April 1 at the Hotel Witter, Wisconsin Rapids, the following officers were elected:

President—Dr. George L. McCormick, Marshfield

Secretary—Dr. Robert W. Mason, Marshfield

Delegate—Dr. Karl H. Doege, Marshfield

Alternate—Dr. Frank X. Pomainville, Wisconsin Rapids

The program included discussions on "Brachial Birth Injuries" by Dr. Leland C. Pomainville, Wisconsin Rapids; "Clinical Manifestations of Cardiac Pain" by Dr. James J. Smullen, Wisconsin Rapids; and "Health Problems" by Dr. Arthur L. Van Duser of the State Board of Health, Madison.

Medical and Dental Societies of Dodge and Columbia Counties

The annual meeting of the Medical and Dental Societies of Dodge and Columbia Counties was held at the Hotel Rogers, Beaver Dam, on April 18. The wives of the members were guests at dinner. Dr. Clifford S. Barborka, Chicago, spoke on "Nutritional Problems in War Time." The meeting was well attended.

SOCIETY RECORDS

New Members

J. J. Burby, Wausau.
M. M. Lavine, Melrose.
C. G. Steinke, Goodman.
L. T. Servis, Milwaukee.
G. R. Randall, Milwaukee.
A. T. Buscalgia, Milwaukee.
T. C. Clarke, Beaver Dam.
W. G. Merrill, Janesville.
C. H. Mason, Superior.
L. G. Nezworski, Hawthorne.
D. M. Willison, Eau Claire.
P. M. Wilkinson, Oconomowoc.
L. L. Sanford, Statesan.

W. A. Niebuhr, Waukesha.
E. E. Kern, Mukwonago.
R. J. Dancey, Statesan.

Changes in Address

Julius Blom, Woodville, to Midelfort Clinic, Eau Claire.

G. G. Drescher, Englewood, Colorado, to 2544 South La Fayette, Denver, Colorado.

Allan Filek, Green Bay, to State Board of Health, Madison.

F. A. Hellebrandt, Madison, to 718 5th Street, SW, Rochester, Minnesota.

E. H. Federman, Randolph, to Horicon.

M. P. Ohlsen, Monticello, to 3477 South 37th Street, Milwaukee.

J. M. Grinde, Oakland, California, to De Forest.

News Items and Personals

Dr. Harry A. Keenan, Stoughton, has been selected by *Look*, nationally known pictorial magazine, as the typical home-front physician in war time. In accordance with its custom of featuring each week a story and pictures of typical American events or personages from all over the country, the magazine will publish a complete story of the present activities of Dr. Keenan. As the magazine's choice, he represents the group upon whom the community depends for protection and guidance in health and whose great burden is to double its work in order to relieve younger doctors for military service.

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At a meeting of physicians at St. Joseph's Hospital, Superior, *Dr. John R. Goodfellow*, Superior, was chosen president of the staff of the hospital. He fills the vacancy left by the death of Dr. Thomas J. O'Leary, Superior.

—△—

The Portage County board of supervisors recently named *Dr. Frederick A. Marrs*, Stevens Point, to fill the unexpired term of the late Dr. Carl von Neupert, Stevens Point, as county physician.

—△—

At Washington, D. C., on Tuesday, March 23, at a testimonial dinner marking his retirement as State Health Officer of Wisconsin after thirty-nine years of service, *Dr. Cornelius A. Harper*, Madison, was elected to honorary life membership in the American Social Hygiene Association and in the Conference of State and Provincial Health Authorities of North America. In the presence of health officials of Canada, Mexico, and the United States, he was cited as one who had initiated "major advances in mental hygiene, venereal disease control, tuberculosis reduction, child welfare, and general sanitation in Wisconsin."

—△—

Dr. Marcos Fernan-Nunez, professor of pathology at the Marquette University School of Medicine, Milwaukee, addressed the combined medical staffs of the Army General Hospital No. 17 (Harper Unit) and the Post General Hospital of Camp McCoy, Sparta, on April 5. The subject of his lecture was "War Problems in Tropical Diseases."

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Centralizing the interests of its March meeting upon medicine, the Candlelight Club of Oshkosh was addressed by two Oshkosh physicians, *Dr. Leonard M. Smith* and *Dr. Ethan B. Pfefferkorn*. Dr. Smith spoke on "Modern Medicine," and Dr. Pfefferkorn on "The Impact of the War on Medicine and Health." The talks were followed by an interesting question and answer period of discussion.

—△—

At the April meeting of the Milwaukee Surgical Society at the University Club, Milwaukee, on Friday, April 3, the speaker was Major T. N. Horan, formerly of Detroit and now stationed at Camp McCoy, Sparta. Major Horan discussed "Kidney Biopsy" and also "Peritoneoscopy."

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Dr. Allan Filek, director of the Division of Tuberculosis of the State Board of Health, addressed the Madison Women's Club March 24. The subject of his discussion was "Organization and Activities of the State Board of Health."

—△—

Dr. Eben J. Carey, dean of the Marquette University School of Medicine, Milwaukee, gave two addresses in Superior on March 17. At a noon meeting of the Rotary Club of Superior, Dr. Carey spoke on "Medical Advances in the War of Interest to the Public." At an evening meeting of the Interstate Academy of Medicine, Superior and Duluth, he gave a talk on "Motor Nerve Endings in Health and Disease."

—△—

Leaders in our nation's medical profession, universities, armed services, and drug and medical supply industries took part in a recent meeting of the National Conference on Planning for War and Postwar Medical Service held in New York City under the auspices of the Carlos Finlay Institute of the Americas. This represents a pretentious and potentially important effort made by medicine and supporting industries toward planning for postwar medical services.

Among the topics discussed by authorities at this meeting were "War and the Migration of Tropical Diseases," "Epidemiology of Influenza," "Malaria—a World Menace," "Nutritional Diseases as a Postwar Problem," "Postwar Need for a Medical and Other Trained Personnel," "Postwar Channeling of Drugs and Other Medical Supplies," "Trends in Scientific Research," "The Health Problems of the Americas," "Health — a World Problem," "The

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Place of the American Red Cross in Medical Rehabilitation," and "American Medicine's Contribution to the Postwar World."

—△—

At the regular staff meeting of the Wisconsin General Hospital on April 20, *Dr. K. L. Puestow*, associate professor of medicine at the University of Wisconsin Medical School, spoke on "Sigmoidoscopic and Radiologic Correlation in Diagnosis and Treatment of Colonic Disorders."

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Dr. Michael W. Shutkin, Milwaukee, spoke on "Peritoneoscopy" at the March meeting of the Milwaukee Gastroenterological Society. Following his talk, he gave an instrumental demonstration.

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The Milwaukee Oto-Ophthalmic Society held its regular meeting on Tuesday, April 13, at the University Club, Milwaukee, and was addressed by Dr. Harold Falls, assistant professor of ophthalmology at the University of Michigan, Ann Arbor, Michigan. The subject of his talk was "Hereditary Ocular Syndrome."

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At the Sixteenth Annual William Snow Miller Lecture presented by Phi Beta Pi at the auditorium of the Service Memorial Institute, Madison, on Thursday, April 15, "Arthroplasty" was discussed by Dr. M. N. Smith–Peterson, clinical professor of orthopedic surgery at Harvard Medical School. Colored movies were shown in connection with the lecture.

BIRTHS

A son, Thomas Locke, to Dr. and Mrs. John M. Grinde, De Forest, on March 28.

A son, James Erwin, to Dr. and Mrs. E. C. Van Valin, Sussex, on March 20.

A son, Robert Durkin, to Captain and Mrs. John F. Cary, formerly of Sheboygan.

MARRIAGES

Dr. Friedrich Eigenberger, Sheboygan, and Cordelia Schrader, Sheboygan, on March 20 at Kohler.

DEATHS

Dr. Herman F. Prill, 68, Augusta, died Sunday morning, April 11. Dr. Prill was graduated from the Milwaukee Medical College in 1902. At the time of his death, he was a member of the Eau Claire–Dunn–Pepin County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow and one sister, Mrs. L. M. Goss of Eau Claire.

Dr. George J. Pomainville, 62, mayor of Nekoosa and for thirty-four years a practicing physician in the southern part of Wood County, died Saturday, April 12, at his home, following a lingering illness. He had been active in his profession and in his city administrative duties until going to Rochester, Minnesota, for medical attention a month before his death.

The parents of Dr. Pomainville were among the earliest pioneers to settle in Nekoosa, his birthplace. He received his medical training at Milwaukee Medical College from which he was graduated in 1904. He was a past-president of the Wood County Medical Society and was long a member of that society, the State Medical Society of Wisconsin, and the American Medical Association.

Four children survive him: Dr. H. G. Pomainville, Nekoosa; Dr. L. C. Pomainville, Wisconsin Rapids; Mrs. Carol F. Buehler, Nekoosa; and Attorney George C. Pomainville, Longmont, Colorado. Other survivors are five grandchildren and two brothers, Dr. F. X. Pomainville and E. N. Pomainville, both of Wisconsin Rapids.

COMING EVENTS

American Board of Obstetrics and Gynecology

The general oral and pathologic examinations (Part II) for all candidates will be conducted at Pittsburgh, Pennsylvania, by the entire Board from Wednesday, May 19, through Tuesday, May 25, 1943. The Hotel Schenley in Pittsburgh will be the headquarters for the Board, and formal notice of the exact time of each candidate's examination will be sent him several weeks in advance of the examination dates. Hotel reservations may be made by writing direct to the Hotel.

Candidates for reexamination in Part II must make written application to the secretary's office not later than April 15, 1943.

The Pittsburgh Obstetrical and Gynecological Society will hold a subscription dinner meeting at the Hotel Schenley on Saturday evening, May 22, 1943, at 7:00 p. m. Candidates for the examinations are cordially invited to attend. Reservations may be made by writing to Dr. Joseph A. Hepp, secretary of the Society, at 121 University Place, Pittsburgh, Pennsylvania.

The Office of the Surgeon-General (U. S. Army) has issued instructions that men in Service, eligible for Board examinations, be encouraged to apply and that they may request orders to detached duty for the purpose of taking these examinations whenever possible.

Candidates in military or naval service are requested to keep the secretary's office informed of any change in address.

Deferment without time penalty under a waiver of published regulations applying to civilian candi-

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dates will be granted if a candidate in service finds it impossible to proceed with the examinations of the Board. Applications are now being received for the 1944 examinations. For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

American Medical Association

The regular annual session of the House of Delegates of the American Medical Association will be held in the Red Lacquer Room of the Palmer House, Chicago, beginning Monday, June 7, at 10:00 a. m. The President-elect will be installed as President at a meeting to be held at 8:00 p. m., Tuesday, June 8.

There will be no Scientific Assembly of the Association during the year 1943.

Michael Reese Hospital Cardiovascular Department

The Cardiovascular Department of the Michael Reese Hospital offers a full-time, intensive graduate course in Electrocardiography presented by Dr. Louis N. Katz, director of cardiovascular research at the Hospital, during the two weeks' period from August 16 to August 28.

This is an intensive course offered to the general practitioner. There will be practice on several electrocardiographic machines and discussion of the principles of their construction and use. There will be sessions on interpretations of electrocardiograms illustrated by lantern slides and practice by the student with unknown records. Routine records taken during the time of the course will be discussed. Emphasis will be placed on chest leads and on the importance of the electrocardiogram in coronary sclerosis and myocardial infarction. The mechanism and interpretation of heart irregularities will be developed.

As group and individual instruction will be given, the course is open to both the beginning and advanced student in Electrocardiography. It is planned to individualize the course so that at the end of the period each student will be capable of taking and properly interpreting routine electrocardiograms. In order to accomplish this purpose, the class will be limited in number. It is imperative, therefore, that reservations be made early.

The fee for the course is $100. Reservations will be made upon receipt of $10.00, which will be applied on the tuition. An hourly program of the course will be sent on request.

For further information, write to the Michael Reese Hospital, Cardiovascular Department, 29th and Ellis Avenue, Chicago, Illinois.

Illinois State Medical Society

Many men in uniform will be present at the 1943 annual meeting of the Illinois State Medical Society at the Palmer House, Chicago, on May 18, 19, and 20, for this is to be featured as a war meeting. Physicians from Wisconsin, as well as those from other adjoining states, are invited to register, receive a guest badge, and attend any of the sessions.

Individual section meetings will be held on Tuesday and Wednesday afternoons, while the morning sessions will be joint meetings with all scientific sections participating. The Oration in Surgery will be presented by Willis D. Gatch, M. D., dean and professor of surgery, Indiana University School of Medicine, at 11:00 a. m., May 19, and the Oration in Medicine by James E. Paullin, M. D., Atlanta, president-elect of the American Medical Association, at 9:00 a. m., May 18.

Catholic Hospital Association

A Wartime Conference of the Catholic Hospital Association of the United States and Canada will be held at the William Penn Hotel in Pittsburgh, Pennsylvania, from Friday to Monday, June 11 to 14, under the patronage and by the invitation of the Most Reverend Hugh C. Boyle, D. D., Bishop of Pittsburgh.

The American Board of Internal Medicine

The regional oral examinations of the American Board of Internal Medicine will be held in accordance with the following schedule:

Philadelphia—May 26 to 29, inclusive, at the Philadelphia General Hospital.
Chicago—June 9 to 11, inclusive.
New Orleans—Dates to be announced later.
San Francisco—Dates to be announced later.

The written examination of the Board will be held on October 18, 1943. All applications for the October examination should reach the following address on or before September 1, 1943, if consideration is desired:

THE AMERICAN BOARD OF INTERNAL MEDICINE
1301 University Avenue
Madison, Wisconsin

Candidates desiring admission to oral examinations in the subspecialties recognized by the Board should file their applications by the same date, September 1.

THE PRESS

Doctor and Servicemen

"To the Journal: Recently we made the acquaintance of a young coastguardman and his wife. Because of his months of active duty in different theaters of war, he was given shore duty as a reward and transferred to Milwaukee. Not knowing anyone when they arrived here, it was their fate that within a few days the wife was taken ill and required a surgical operation. Upon the recommendation of their landlady they consulted her doctor, who performed the operation. When the wife was released from the hospital the coastguardman went to the doctor's office and requested a bill. The doctor looked up at him and asked whether he had a lot of money, to which the young fellow replied

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You will find that Page Special Milk not only provides an ideal vehicle to administer more than the necessary Vitamin D usually required for the prevention of rickets in normal infants, but permits calcium retention and is adequate for best growth. The additional Vitamin A plus the amounts of Vitamin A usually found in milk enhances the nutritive value of the milk, especially important now because of the loss of a certain amount of Vitamin A due to rationing of fats. An orange and black label serves to identify Page Special Milk at chain or independent food stores.

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The two bars below represent the average degree of healing of rickets on 16 laboratory rats over a seven day period. Bar number one represents the average of 8 rats used as a positive control and fed a seven day dose of Reference Cod Liver Oil equal to *43.48 mgs. The second bar represents the average of 8 rats fed 6.0 cc. of Page Special Milk, assayed at 25 USP units per fluid ounce.

Conclusion: The Vitamin D activity of 6.0 cc. of sample is greater than that of 43.48 mgs. of Reference Cod Liver Oil. Page Special therefore contains more than 5.0 USP units of Vitamin D per 6.0 cc. —more than the 25 USP units per fluid ounce stated on the can. Thus there is an ample margin of safety when customary amounts of milk are taken.

*The Vitamin D content of 43.48 mgs. of Reference Cod Liver Oil equals 5.0 USP units.

that he didn't have much. To quote the coastguardman, the doctor then remarked, 'Well, just give me a cigarette and we'll call it square.'

"You can imagine what this young man felt and you can also imagine how words to thank the doctor just would not come. In these dark days an action like this renews our faith in real Christianity and does much to bolster our morale.

"I can't mention the doctor's name, but you can well realize that the story is repeated constantly. And I want him to know that all of us who know of him through the grand thing he did, feel that when God cast the mold that produced our great humanitarian, President Roosevelt, he didn't discard it, but from it also molded great men like this Milwaukee doctor.

"Needless to say that the young serviceman, though he may be transferred to other cities, will always have Milwaukee in his memory as the kindliest and friendliest city in the world. I do hope that you will print this experience, because this doctor is indeed a fine example of Christian Americanism. Mrs. W. C. K." From *The Milwaukee Journal*, March 21, 1943.

TRADE NEWS

New Genito-Urinary Analgesic and Antiseptic Introduced by Squibb

A new analgesic and antiseptic for use in genito-urinary conditions has been added to the line of E. R. Squibb & Sons under the name "Cajandol." A preparation of 5 per cent oil of cajeput dissolved in peanut oil, with 0.1 per cent propylparahydroxybenzoate as preservative, Cajandol was developed at the Brady Urological Institute, Johns Hopkins Hospital, and has been in use there during the last several years.

Clinical experience has shown that Cajandol alleviates pain and distress due to instrumentation and fulguration. It is also beneficial in many types of acute and chronic cystitis and other pathologic conditions of the bladder.

In treating these conditions, 10 cc. to 15 cc. of Cajandol are instilled into the bladder through a catheter at daily or bi-weekly intervals. In a few cases, Cajandol has been injected up the ureter during the use of the Councill stone extractor and has facilitated withdrawal of this instrument when there has been difficulty due to spasm of the ureter.

Cajandol is supplied in pint bottles only.

Frederick Stearns & Company Announces Appointment

Maurice L. Moore, formerly research chemist in the Medical-Research Division of Sharp and Dohme, Inc., has joined the scientific laboratories of Frederick Stearns & Company, Detroit, Michigan, as Director of Organic Research. He received his Ph. D. from Northwestern University in 1934 and held a postdoctorate Fellowship at Yale University from 1934 to 1936. Since 1936 he has been a member of the Research Division of Sharp and Dohme, where he has done extensive work in the sulfonamide field.

Clinical Evaluation of "Seconal Sodium"

During the course of a year, Dietrich (Anesth. & Analg., 22:28, 1943) attempted to evaluate "Seconal Sodium" (Sodium Propyl-methyl-carbinyl Allyl Barbiturate, Lilly) as a sedative in general pediatric practice. Over 3,700 doses of the drug were administered to more than 500 children and infants, both private and ward patients, without any untoward effects on pulse, temperature, blood pressure, or cerebrospinal fluid pressure. The drug proved to be an excellent general sedative possessed of some analgesic action, and in tetanus and in the performance of certain otherwise painful procedures where a general anesthetic was not desirable, such as pinch grafts, lumbar punctures, myringotomies, and incision and drainage of minor abscesses, it was of particular value.

When the age of the patient and freedom from gastric symptoms permit, "Seconal Sodium" should be given by mouth. When administered by rectum, however, its action is only slightly retarded. The intact capsule may be inserted in the manner of a suppository by first pricking each end of the capsule with a pin; or, where fractional doses are desired, the powder may be suspended in tap water and given by rectum with a small syringe.

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It is well to bear in mind that *dried brewers yeast, weight for weight, is the richest food source of the vitamin B complex*. For example, as little as one level teaspoonful (2.5 Gm.) Mead's Brewers Yeast Powder supplies: 45 per cent of the average adult daily thiamine allowance, 8 per cent of the average adult daily riboflavin allowance and 10 per cent of the average adult daily niacin allowance.

This is in addition to the other factors that occur naturally in yeast such as pyrodoxin, pantothenic acid, etc.

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Westinghouse Supplies Trailer X-Ray Units For Russia

Thirteen mobile trailer units, each compactly fitted with portable X-ray equipment that can be set up during battle or air raids in 20 minutes, have been purchased in this country by English donors for the Russian army.

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with X-ray units manufactured by the Westinghouse X-ray Division, Baltimore, and were supplied by the Westinghouse International Company. Each trailer carries complete facilities for fluoroscopy and radiography.

The X-ray equipment can be quickly removed from the trailer and set up in a shack or tent by two members of the medical crew assigned to each unit. These two men, an X-ray specialist and his assistant, can then examine wounded soldiers or civilians for bone fractures, shrapnel wounds and other war injuries.

The fluoroscopic facilities of the trailer unit enable the X-ray specialist to determine whether a wounded soldier or civilian can be safely moved to a hospital for expert care, or whether he must be treated immediately.

With the radiographic facilities, the X-ray technician can make a permanent record of an injury for immediate study or to aid in treatment after a victim has been hospitalized. Complete dark room equipment, including chemicals, films and a developing tank, is provided for making permanent records of injuries on regular size X-ray films.

The Journal Bookshelf

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Clinical Anesthesia. A manual of clinical anesthesiology. By John S. Lundy, M. D., head of section on anesthesia, Mayo Clinic; professor of anesthesia, Mayo Foundation for Medical Education and Research, Graduate School, University of Minnesota; diplomate and member of the American Board of Anesthesiology, Inc.; member of the subcommittee on anesthesia, National Research Council. Cloth. Price $9. Pp. 771, with 266 illustrations. Philadelphia: W. B. Saunders Company, 1942.

The book is a complete, exceptionally detailed account of the technic of anesthesia and related practices as carried out at the Mayo Clinic. There is little or no discussion of the methods used elsewhere or of the opinions and experiences of other anesthetists.

It would have been desirable to have included more information on certain subjects. The discussion of spinal anesthesia omits mention of heavy and light solutions, and inadequately describes the use of agents other than procaine. The diagnosis and treatment of toxic reactions due to local anesthetic agents are only briefly mentioned. The pharmacology, technics and complications of inhalation anesthesia are comparatively neglected.

The chapters on the technic of local anesthesia are very comprehensive and will fill a long felt need for an up-to-date source of reference. The author has had extensive experience with intravenous anesthesia, and his discussion of its use is excellent.

The indexing is not as complete as might be desired for a reference book. N. B. & B. O.

The Hand. Its disabilities and diseases. By Condict W. Cutler, Jr., M. D., F. A. C. S., associate surgeon, Roosevelt Hospital; director of surgery, Welfare Hospital; consulting surgeon, New York Dispensary; chief, Emergency Medical Service, New York County; fellow of the American Surgical Association. Cloth. Price, $7.50. Pp. 572, illustrated. Philadelphia: W. B. Saunders Company, 1942.

This book fills the requisites of a practical guide for diagnosis and treatment of conditions of the hand. Although infections of the hand probably are more numerous than any other conditions found in this region, this book covers a much wider field and therefore is of greater practical use to the general practitioner.

In addition to acute infections, it includes specific and chronic infection, wounds, burns, fractures, particularly characteristic of the hand, dislocations, repair and reconstruction of injuries to the hand, a section on deformities and tumors. Also of great importance is a chapter on constitutional diseases affecting the hand.

The first chapter in the book is an accurate and detailed discussion of the anatomy of the hand and forearm. There has been a need for just this type of work and book. This volume will be of definite practical aid to doctors in private practice who deal with most of the infections and injuries to the hand first. It would also be of value to physicians in industrial plants who are usually the first to treat many conditions involving the hand. H. W. W.

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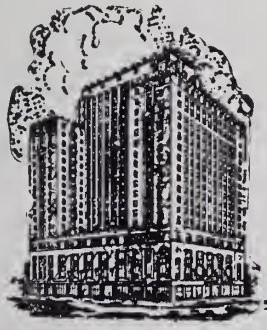

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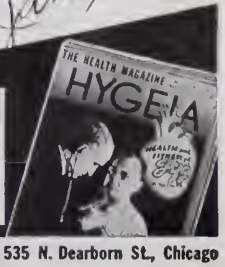

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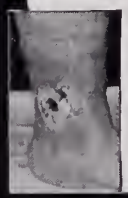

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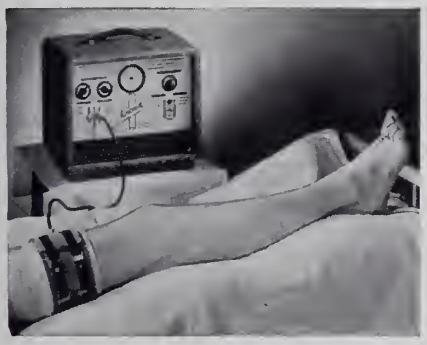

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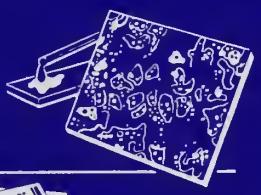

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By Elexious T. Bell, M. D.

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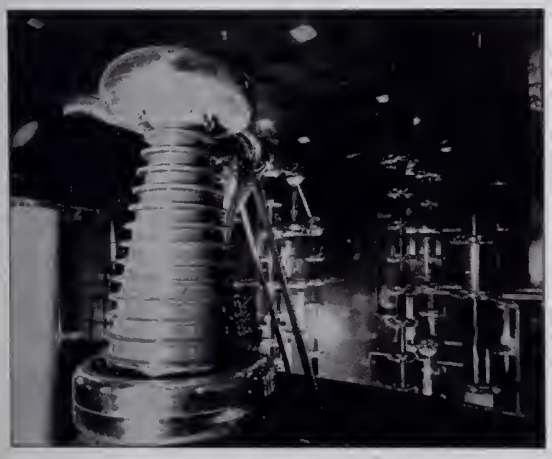

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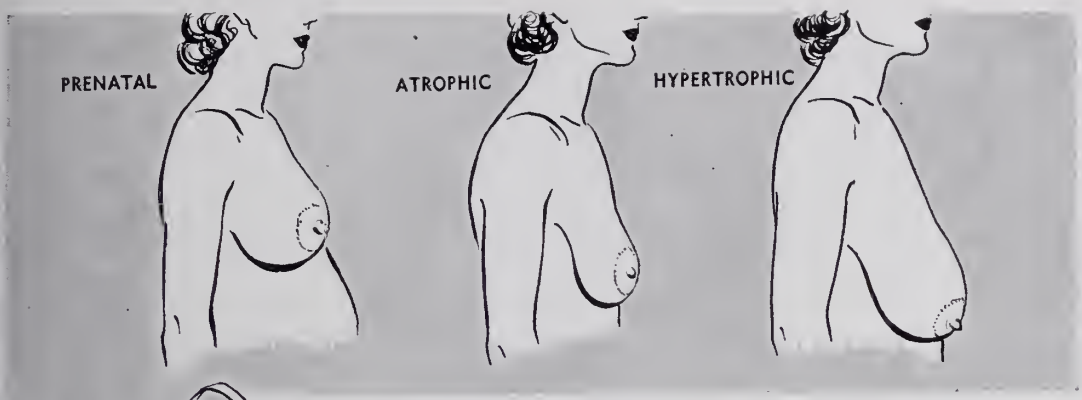

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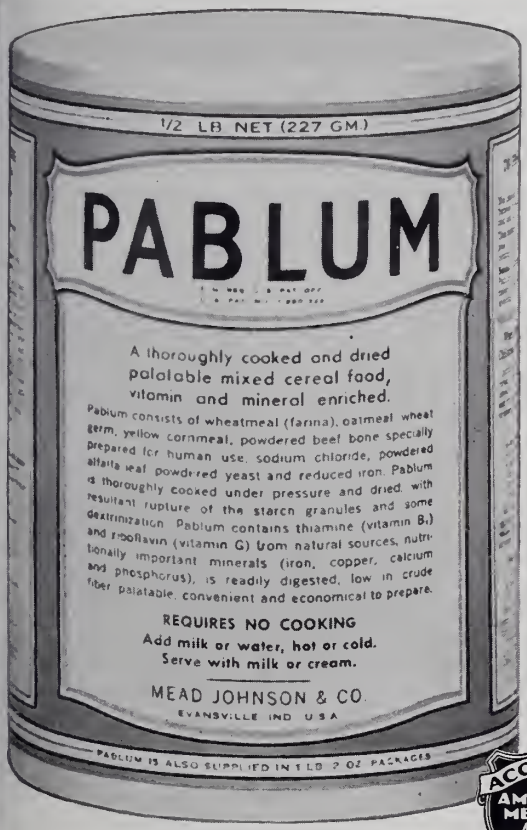

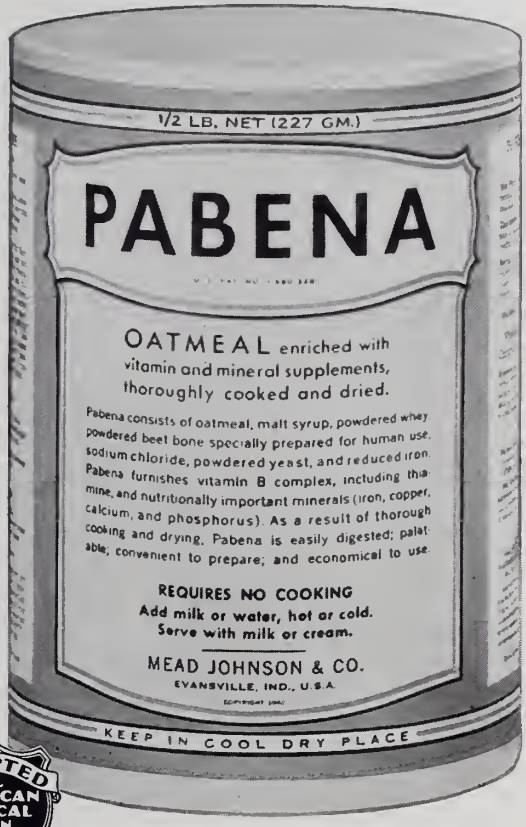

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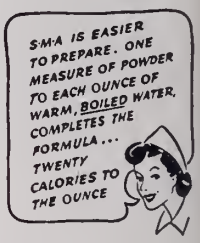

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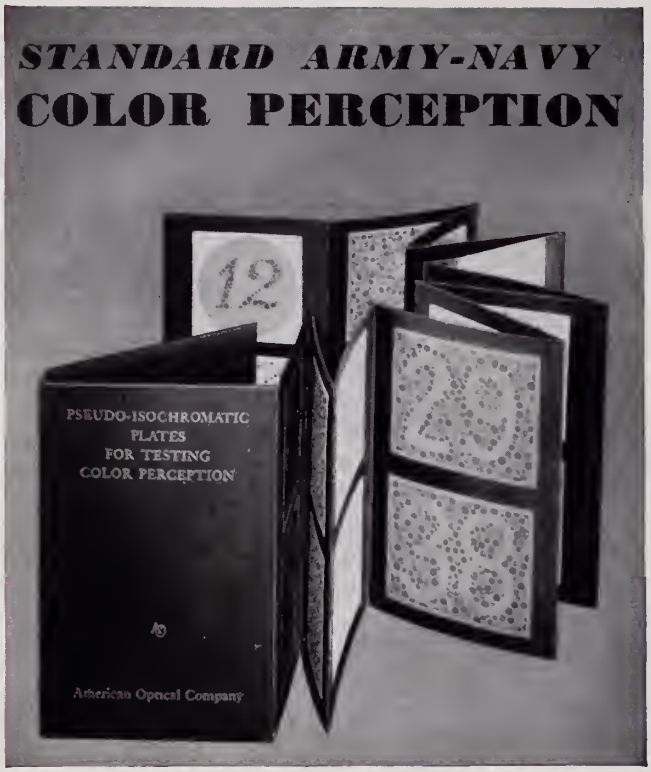

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Physiology of the Heart and Circulation*

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FROM a functional point of view, the circulatory mechanism of the human body consists of a cardiac power plant, a distributing division for the interchange of metabolic substances, and a collecting system to return the blood to the central pump. Because the capillaries and venules are the only regions where exchange between the tissues and the blood can occur, these structures of the distributing division are the keystone of the whole system. However, making a practical study of the capillaries is difficult, and, since a circulation cannot be maintained if any one part fails, the physiology of the cardiovascular system has been concerned mostly with the heart, the arteries, and the veins. Because accurate conclusions can never be drawn concerning the functional capacity of the circulatory system without a thorough understanding of elementary principles, the important functions of the heart, the arteries, and the veins will be reviewed.

The Work of the Heart

The heart is a four-chambered pump. The auricles are reservoirs with a capacity somewhat greater than the ventricles. Their role as injectors to fill the ventricles is a minor one, although in auricular fibrillation the loss of this function does encroach on cardiac reserve to a certain extent. Regurgitation into the auricles is prevented by the resistance of the venous stream and the low ventricular pressure previous to complete closure of the auriculoventricular valves. The ventricles are force pumps. The pressure they exert on their contents is the driving force for the entire circulation. Although the blood flow is modified by other factors, the energy on which it depends is derived from the contractile strength of the cardiac muscle.

The external work of the heart consists in the pressure developed upon the blood and the velocity given to it. Because these factors can be measured or closely estimated, we can find in work units how much work the heart does and how efficient it really is. About 20 to 28 per cent of its total energy may appear as work. It is thus equal to a good steam engine. Its muscle is also particularly resistant to toxins, oxygen want, decreased blood supply, and overwork.

The Load of the Heart

Physiologically the work of the heart is normally determined by its load. The load can be defined in one or both of two terms: first, the resistance against which the heart works, which is the mean pressure in the aorta and pulmonary artery; second, the pressure head for filling, which is the mean pressure in the vena cava and right auricle on one side and in the left auricle and pulmonary veins on the other. In considering the physiologic pathology of the heart, it is just as important to know the load of the heart as it is to know its contractile power. As a matter of fact, it is clinically impossible to evaluate contractile power except in terms of load.

The venous load of the heart changes with the rate at which blood returns to the heart, the variations in blood volume, and the ability of the heart to empty the venous systems. A measurement of venous pressure gives information as to the venous load on the heart and is, therefore, one of the few indirect ways of estimating the contractile power of

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the heart. If the peripheral venous pressure in the recumbent position rises above 200 mm. of water, it is evidence that the heart is not meeting its load and that decompensation may be imminent.

The arterial load depends on the caliber of the peripheral blood vessels, the elasticity of the arteries, the blood volume, the blood viscosity, and the rate at which the left ventricle ejects the blood. Under normal conditions, there is more or less of a dynamic balance between all these factors, and the arterial load of the left ventricle tends to remain constant. However, it varies under physiologic conditions, particularly in exercise, but it is brought back to normal by the action of the aortic and carotid sinus regulatory nerves.

The Contractile Power of the Heart

The most important property of the heart both in health and disease is its contractile power. How great this may be is often the one important question in the minds of both the physiologist and the clinician. The question "How is my heart?" is probably the most common the doctor hears. All experimental and clinical investigations on cardiac problems are really directed to this point. Aside from inherent genetic differences in the quality of the myocardial substance, the contractile power of the heart has been shown to depend upon the size of the heart or, more accurately, the length of the myocardial elements.

This fact allows an adjustment of the contractile power of the heart to the existing venous or arterial load. If venous pressure increases as it does in the vasodilatation of exercise, the right auricle is more than usually distended. Therefore, it contracts more strongly and forces more blood into the right ventricle. In turn, the right ventricle also is thus more than usually distended and, therefore, forces more blood into the pulmonary circulation. As soon as the blood reaches the left auricle, the process is repeated. The result is cardiac adaptation to the venous load. If the arterial load is increased for a short time, the left ventricle fails to meet the load and puts out less blood. This means that more blood is retained in the ventricle, which thereby has its fibers lengthened. This increases the contractile power and results in ejection of the original amount of blood. However, the heart remains dilated in proportion to the extra load. This fact that the contractile power of the heart depends on the length of fiber and, therefore, on the load is what is known as Starling's law of the heart.

The increase in work which accompanies dilatation cannot continue indefinitely. When the cardiac fibers are stretched beyond a certain length, the stroke output, that is, the work done by the heart, decreases. The heart has at this point exceeded the limit of its reserve, so far as the mechanism of dilatation is concerned.

There are other ways in which the heart can meet an additional load. An obvious one is by increasing its rate. When the venous load is large, distention at the mouths of the great veins stimulates sensory nerves which carry impulses to the cardioinhibitory center releasing its tonus and thereby accelerating the heart rate. The minute volume, which is the measure of the circulation, physiologically depends both on the amount of blood thrown out at each beat and the number of beats. In the dog, as the rate slows from 80 to 60 per minute, the rate reduces the minute volume to the point of circulatory failure even though the heart dilates and the stroke volume increases. As the heart rate increases from 80 to 120, the minute volume increases even though stroke volume slowly falls. From 120 to 180, the stroke volume becomes less, because the falling time is abbreviated and somewhere around 180 to 200 circulatory failure appears. In man, the picture is much the same. Normally the heart can function at rates between 30 and 160 per minute. Above or below these levels, there is little or no reserve.

Type of Rhythm

The type of rhythm is also of great importance. Ventricular tachycardia reduces minute volume more than does auricular. This is because all parts of the ventricle do not contract in an effective sequence when the contraction waves spread from a ventricular focus. Scattered premature beats do

not materially reduce cardiac output. However, if they become numerous or irregular, the effect is marked. The irregular series of ventricular contractions which occur in auricular fibrillation is unfavorable for minute volume, because many of the beats are ineffective and little blood is delivered.

The cardiac compensations so far mentioned are those which come into action the moment the load is increased. A slowly appearing adaptation is cardiac hypertrophy. This consists not only in an increase in the size of the fibers but also in the number of fibrils. The exact stimulating agent has not yet been determined, although the best evidence favors mechanical factors. The clinical conditions which are followed by cardiac hypertrophy are those which result in excessive dilatations, aortic stenosis, valvular defects, adhesive pericarditis, diminished contractions due to toxic agents, and patent ductus arteriosus of the right ventricle. In agreement with this point of view, Eyster has shown on animals in our laboratory that a sudden temporary dilatation in dogs may evidence subsequent hypertrophy. Hypertrophy seems then to depend on an increased stretch for its fundamental stimulus.

Physiologically, failure in cardiac function may be thought of as direct or primary whenever the contractility and irritability of the myocardium is lowered by toxic agents (drugs and infections), impaired blood supply from coronary sclerosis, or prolonged strain from hypertension, and indirect or secondary when the action of the ventricles is hampered because of reduced venous return, as in hemorrhage and shock, or a high venous pressure when accompanied with excessive dilatation. All these conditions result in a decreased oxygen consumption and a decreased ability of the heart to release energy for the propulsion of blood.

Physiologic Stages of a Failing Heart

Whatever the cause, three very definite stages on a physiologic basis are characteristic of a failing heart. First, there is compensation by the physiologic mechanisms already described. This is a normal physiologic process, and no untoward symptoms are observable. It is a stage which may be studied on animals in the laboratory but which in man does not ordinarily come to the clinician. Its detection by physiologic means is one of the great problems in cardiology. Second, there is a stage of diminished cardiac reserve. At this time the dilatation from increased return even in moderate exercise exceeds the physiologic bounds, and dyspnea becomes apparent. Third, there is the stage of congestive failure. Cardiac dilatation, high venous pressure, cyanosis, and edema are seen, all because the heart cannot empty the venous cisterns and keep the circulation moving.

The vital function of the circulatory system is to carry nutrients to and wastes from the body cells. These exchanges occur in the regions of the capillaries and venules. They depend not only on the processes taking place in the walls of the capillaries and venules but also upon physical conditions in the distributing system of arteries and arterioles and in the collecting system of veins.

Arterial blood pressure is determined by the force of the heart beat and the peripheral resistance of the arterioles. It is maintained between systoles by the elasticity of the arteries. In recent years, a knowledge of diastolic pressure has assumed more and more importance. It is known to show less variation than the systolic; it represents the constant load the vascular walls are carrying; it varies more with the conditions of peripheral vessels. It should also be remembered that an increase in peripheral resistance or in the heart rate always raises diastolic pressure more than systolic and thus decreases the pulse pressure. On the other hand, decreased arterial elasticity raises the systolic but lowers the diastolic pressure. A distinction may thus occur between central and peripheral arteriosclerosis.

The greatest peripheral resistance is found in the arterioles, because here the arterial branchings increase the frictional surface far more than they do the cross-sectional area. In the capillaries and venules the pressure is low, because the total cross sectional area has increased some 800 times over that in the aorta. The smooth muscles in the walls of the arterioles allow variations in the diameter of the arterioles, thus rais-

ing or lowering arterial pressure and tending to produce the opposite effect on venous and capillary pressure.

Studies on Hypertension

The application of physiologic principles to circulatory problems is well illustrated in the studies on clinical hypertension. Since an elevated blood pressure may be due to several factors, the exact reason for hypertension has been difficult to discover. Cardiac output, force of beat, peripheral resistance, volume of blood, and blood viscosity must all be examined. Physiologists have long believed that the condition was brought about by increased peripheral resistance, and in the last few years the work of Goldblatt and Page has uncovered at least some of the mechanisms involved. It now seems clear that there is constriction of the arterioles. Since the skin remains normal in color, the capillaries and the venules are excluded. In the fundus of the eye, constricted arterioles may actually be seen. The arterioles are under the control of the vasomotor nerves as well as the control of a number of chemical agents circulating in the blood. There might well be a nervous or cerebral type of hypertension, but with the discovery that an ischemic kidney produces renin, which when activated to angiotonin is sufficient to keep the arterioles of the body constricted, a renal type of hypertension becomes understandable. Cardiac output is normal in both experimental and clinical hypertension, and there is no evidence that the peripheral blood flow is decreased even in the face of the greater vasoconstriction. To meet a constantly increased resistance, there must be a considerable increase in the force of the heart beat. Dilatation, hypertrophy, and decompensation follow in the usual sequence. The full meaning of the designation, "cardiorenal," thus becomes apparent on a physiologic basis.

The Circulation

The real value of a distributing system depends on the speed of movement and the total amount of material distributed. The speed of blood flow in the arteries and veins, that is, the circulation time, has therefore been of great interest both to the physiologist and the clinician, and many ingenious methods have been used to determine it. If a solution of magnesium sulphate, calcium gluconate, and copper sulphate is injected into an arm vein, a hot flash is felt shortly afterwards in the tongue, perineum, hands and feet. Saccharin introduced in the same way gives a taste of sweetness. Cyanide will cause a sharp increase in respiration as it strikes the carotid sinus. Radioactive material may be injected and its arrival at a given place be determined by a Geiger counter. By these methods one may estimate the average speed of flow in the arteries and veins.

In the obliterative arterial diseases, the "ventricle to foot" speed of flow is usually decreased, but not always. Circulation time is faster in hyperthyroidism and anemia. It is little changed in hypertension. Sympathectomy to one limb markedly shortens the circulation time. Exercise has the same effect, and the same physiologic mechanisms are involved. Elevating an extremity increases the speed of venous flow. Surgical operations reduce the speed of venous return from the lower limbs, which may have a relation to thrombosis.

The total volume of blood that flows through an organ is of as much or more importance than the mere speed with which it flows. When an organ becomes functionally active, its arterioles dilate. This does not lower the general blood pressure, however, for there is compensatory vasoconstriction elsewhere, the so-called Loven reflex. The head of blood pressure is thus kept at the usual height, which insures a greater volume of blood passing through the organ. If the capillaries dilate, the velocity of flow is decreased, but the total volume of blood passing through may remain the same or even be increased. The volume flow of an organ may be determined by the plethysmographic method of Brodie, which depends on the principle that if the venous return is occluded, any swelling of the part represents the amount of blood which enters. The amount of heat that the hand or foot gives off to surrounding water also indicates the

amount of blood flow. The value of studies by these methods in determining the amount of peripheral circulation is obvious.

The Venous Return

Having been distributed and having carried out its nutritive functions, the blood must be returned to the heart to repeat its appointed circuit. The venous flow to the heart is due primarily to the force of the left ventricular contraction. It is furthered by the aspirating action of the thorax, which is in the nature of a lifting pump. It also depends on the quantity of blood relative to the capacity of the capillaries and veins. Another important factor in venous return is the physical support given to the veins by abdominal and skeletal muscles. This transforms the veins into more or less rigid tubes and prevents their stretching under the weight of blood. In this respect, tight abdominal bandages may compensate for lax abdominal muscles. The intermittent contraction of muscles in conjunction with the valves in the veins serves as a means of passing the blood upward to the heart. There are also venopressor and capillary tonus mechanisms under nervous and hormone control.

In recent years, a good deal of attention has been directed to the effect of skeletal muscle tonus on venous return. The alternating contraction of small muscle bundles compresses and empties the intercalated capillaries and venules just as the muscle as a whole presses on and empties the veins. The longitudinal pull of the muscle fibers also keeps up a definite intramuscular pressure. This can be measured by inserting a needle into the muscle and balancing the pressure against a manometer. At one time, the failure of the peripheral circulation was assigned entirely to relaxation of the peripheral blood vessels, especially in the splanchnic area. This might well take place either because of nervous failure or local toxic action. But the loss of muscle tonus would offer another mechanism for peripheral circulatory failure. Loss of motor control over the arterioles and capillaries as well as skeletal muscle would result in the pooling of blood and a slowing of the blood stream. The effective circulatory volume would at once be decreased, and this is the beginning of shock. Shock may be best defined as a decrease in the effective circulatory volume. It matters little whether this volume is decreased by loss to the exterior as in hemorrhage, into the tisues as in traumatic injury, or merely pooled in some part of the body. The real important physiologic result is that the venous return is decreased and that although the arterial blood is still saturated with oxygen, the volume flow is less and the demands of the tissues are no longer met. A failure in venous return is also characteristic of the final stages in many febrile conditions.

In all cases of peripheral circulatory failure, the heart seems to retain its contractile power in large measure until the anoxia becomes extreme. Even a markedly failing heart may be restored in the experimental laboratory by increasing its blood supply. It is even doubtful if anoxemia and anoxia of capillary walls is as important in edema as the concentration of the blood proteins.

BIBLIOGRAPHY

1. Blalock, Alfred: Peripheral Circulatory Failure, Am. Heart J. 23: 147 (Feb.) 1942.
2. Fahr, G., and Ershler, I.: Studies of the Factors Concerned in Edema Formation. II. The Hydrostatic Pressure in the Capillaries during Edema Formation in Right Heart Failure, Ann. Int. Med. 15: 798 (Nov.) 1941.
3. Harrison, T. R.: Arterial and Venous Pressure Factors in Circulatory Failure, Physiol. Rev. 18: 86 (Jan.) 1938.
4. Henderson, Yandell: The Venopressor Mechanism, Science 95: 539 (May 29) 1942.
5. Katz, L. N.: Observations on Cardiac Failure and the Mode of Its Production, Pub. 13, A.A.A. Sc., p. 184, 1940.
6. Kvale, W. F.; Smith, L. A., and Allen, E. V.: Speed of Blood Flow in the Arteries and in the Veins of Man, Arch. Surg. 40: 344 (Feb.) 1940.
7. Wiggers, C. J.: Physiology in Health and Disease, ed. 3, Philadelphia, Lee & Febiger, 1939.

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Pathology of Hypertension*

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PRIMARY, or essential, hypertension may be defined as high blood pressure of unknown etiology. It is to be distinguished from secondary hypertension in which there is some known causative factor such as kidney disease, coarctation of the aorta, or a chromaffin cell tumor of the adrenal medulla. Hypertension is not a circumscribed entity, since the distinction between normal blood pressure and hypertension is made arbitrarily. It is generally agreed that 150:90 mm. mercury is the dividing line in persons over 50 years old, and 140:90 in those under 50 years. Some clinicians and insurance companies use 145:90 as the dividing line between normal pressure and hypertension.

Frequency

Wetherby states that hypertension, in the amount of 150:90 mm. mercury or higher, is found in about 38 per cent of men and 57 per cent of women over 50 years old. Over one-half of the persons with hypertension of this extent have no symptoms. Autopsy studies show that hypertension causes about 13 per cent of the deaths in persons over 50 years old. Cancer is the only disease that causes more deaths than hypertension. Only about one-third of persons with hypertension die from hypertensive disease. Hypertension affects women and men in the proportion of three to two, but more men die of the disease. With corresponding blood pressure, the prognosis as to length of life is much more promising in women than in men, and it is much better in those with a systolic pressure between 150 and 180 mm. mercury than in those with pressure above 180 mm. mercury.

Hypertensive disease affects the heart, the brain, the kidneys, and the retina; there are no primary symptoms from any other organ. Therefore, hypertensive disease may be divided clinically into cardiac, cerebral, and renal types. There is much overlapping, but in the majority the symptoms are chiefly referable to only one organ.

The Cardiac Type

The cardiac type of hypertension may be subdivided into myocardial and coronary groups. The myocardial group comprises over 50 per cent of all hypertensive disease and is equally frequent in men and women. In the compensated stage, the only change is left ventricular hypertrophy. When the left ventricle begins to fail, first there is edema and congestion of the lungs, causing dyspnea and right ventricular hypertrophy. Finally, the right ventricle fails, and the patient develops enlargement of the liver and spleen, edema, and cyanosis. At autopsy one finds an enlarged heart with no valvular lesions and greater hypertrophy of the left than the right ventricle. In vital statistics this disease is usually listed as chronic myocarditis, but there is no inflammation in the myocardium.

The coronary group shows left ventricular hypertrophy with coronary sclerosis or thrombosis. It may occur with or without congestive heart failure. Many patients with coronary disease do not have hypertension. Coronary disease is nearly three times as frequent in men as in women.

The Cerebral Type

Headache and dizziness are common symptoms in all forms of hypertension and are probably referable to increased tension in the small cerebral vessels. The more severe cerebral symptoms are apoplexy (hemorrhage or thrombosis), personality changes, and mental deterioration. Severe cerebral symptoms without prominent paralyses are sometimes called hypertensive encephalopathy. The more severe cerebral

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symptoms are referable to closure or rupture of small arteries with infarction or hemorrhage or to generalized severe narrowing of the arteries of the base of the brain. There is no satisfactory evidence for vasospasm. Between 15 and 20 per cent of hypertensive deaths are due chiefly to cerebral lesions.

The Renal Type

About 12 per cent of hypertensive deaths are due to uremia, the renal insufficiency resulting from severe involvement of renal arteries and arterioles. There are additional cases with some impairment of renal function in which death was due to cardiac failure or a brain lesion. Hypertension with uremia does not show a sex preponderance, but the age distribution in the sexes is different. There are more cases in young women than in young men, and more in older men than in older women.

Inasmuch as many investigators now are paying particular attention to the kidneys as a possible source of a pressor substance, a somewhat detailed description of the renal lesions will be presented. The primary changes are all in the renal arteries and arterioles. When these lesions are severe and of a chronic type, one may find numerous hyaline glomeruli and atrophic tubules, and the kidneys may be markedly shrunken and pitted. The atrophy of the glomeruli and tubules is clearly due to anemia resulting from narrowing or closure of the arteries. Hypertension is, therefore, a purely vascular disease.

In the medium-sized and small arteries, the change is chiefly intimal thickening due to a great increase of elastic and collagenous fibers. In the arterioles, the usual change is a subintimal deposit of hyalin, called arteriolosclerosis.

In comparing the observations of different pathologists, it is important to know the size of the vessel called an arteriole. "Arteriole" is used in the sense of an afferent glomerular arteriole only and does not include the small arteries from which the afferent vessels arise. If one includes the small arteries, then over 80 per cent of all hypertensive patients have arteriolosclerosis, but if only the afferent glomerular vessels are included, the percentage with arteriolosclerosis is much less. The small renal arteries are not a good index of hypertension, since the great majority of nonhypertensive elderly persons show some sclerosis of these vessels.

Hyalinization

In the arterioles there is a subintimal deposit of a hyaline material which varies greatly in thickness. It is not uniformly distributed in different arterioles or in different parts of the same arteriole. The degree of hyalinization may be expressed roughly as grades 0, 1–, 1, 2, 3, and 4. Grade 0 means that no hyalin can be found in any arteriole; grade 1–, a small hyaline deposit in a few arterioles; grade 1, a definite, thin, subendothelial, hyaline layer in most of the arterioles; grades 2 and 3, extensive hyaline deposits without complete occlusion of the arterioles; and grade 4, complete occlusion of the arteriole with hyalinization of its glomerulus. In diabetes the deposit of hyalin is often so thick that a diagnosis of diabetes may be made from this feature alone. Sometimes, especially in persons with diabetes, the efferent arteriole is also hyalinized.

When the arterioles are affected, the small arteries are also involved, and, in some instances of renal insufficiency, closure of small arteries is chiefly responsible for uremia.

In hypertension without renal insufficiency (benign hypertension), the great majority of the arterioles are still permeable to blood, and there is little or no atrophy of the parenchyma. The degree of arteriolosclerosis varies from 0 to 3, and the intimal thickening of the small arteries is not much greater than in a group of nonhypertensive persons of corresponding age.

Hypertension With Renal Insufficiency

Of a large number of deaths due to hypertensive disease, it was found that about 12 per cent resulted from renal insufficiency. "Malignant hypertension" has three different meanings in the current literature. It was used first to mean hypertension with uremia. Keith and Wagener call hypertension malignant when there is hypertensive

retinitis; they do not require an associated renal insufficiency. More recent reports restrict malignant hypertension to a special type of lesion in the arterioles and small arteries, which is perhaps the most satisfactory use of the term.

Chronic Uremia

In about two-thirds of the patients who die of uremia, the renal insufficiency develops slowly in an individual who has had chronic hypertension for many years. At autopsy the kidneys are usually contracted, there are extensive hyaline and fibrous changes in the arteries and arterioles, the majority of the glomeruli are hyaline, and there is extensive atrophy of the parenchyma. This lesion seems to be merely an advanced stage of ordinary hypertension. The arteriolar lesions differ only in intensity from those of hypertension without uremia, namely, the cardiac and cerebral forms.

Acute Uremia

In hypertension that terminates in acute uremia there is usually also a long history of previous hypertension, but the final symptoms are of fulminant character. The blood pressure reaches very high levels, and hypertensive retinitis is prominent. At autopsy the kidneys are often not much reduced in size. The structural changes in the small arteries and arterioles are characteristic enough to establish the diagnosis without reference to the clinical history. The lesions are of three types. The most common lesion is a marked intimal thickening due to loose collagenous tissue. Another very common alteration is thrombonecrosis of the arterioles; the entire vessel wall is necrotic and is fused with a thrombus in its lumen. A third lesion is glomerulitis in an occasional glomerulus. This vascular lesion is different from hyaline arteriolosclerosis and merits a special classification. It may well be called malignant hypertension. The etiology is unknown.

The Relation of Renal Arteriolosclerosis to Primary Hypertension

Three views of the relationship between renal arteriolosclerosis and primary hypertension have been advocated: (1) that arteriolosclerosis causes hypertension; (2) that hypertension causes arteriolosclerosis; and (3) that the two processes originate independently and only intensify one another when associated together.

Arteriolosclerosis Causes Hypertension

If it is true that renal arteriolosclerosis causes hypertension, then all cases of hypertension should show arteriolosclerosis, and one might also expect that all cases of arteriolosclerosis would show hypertension. As a means of studying this problem, microscopic studies of the kidneys were made from 267 nonhypertensive individuals, all over 40 years of age. There were no hypertensive symptoms, the hearts were of normal size, and the systolic blood pressure was always below 140 mm. mercury. All cases of diabetes were excluded. In this control group 17.8 per cent showed renal arteriolosclerosis of grade 1 or higher, and 80 per cent were grade 1. When the cases were arranged with respect to age, it was found that arteriolosclerosis (grade 1 or higher) occurred in about 9 per cent of those between 40 and 60 years old, and in about 30 per cent of those over 70 years old. It is clear, therefore, that renal arteriosclerosis is an age change and that it occurs in a great many elderly individuals who do not have hypertension. If arteriolosclerosis is the only cause of hypertension, it is not clear why these individuals with arteriolosclerosis did not have an elevated blood pressure. It cannot be argued that hypertension was the cause of the arteriolosclerosis in these controls.

In autopsy studies, the frequency of renal arteriolosclerosis in known cases of clinical hypertension is as follows: myocardial type (544 cases) 63.8 per cent, coronary type (264 cases) 53.4 per cent, cerebral type (314 cases) 79.2 per cent. It will be noted that renal arteriolosclerosis is about four times as frequent in hypertensive persons as in nonhypertensive controls; but a great many typical cases, especially of the myocardial and coronary forms, do not show arteriolosclerosis. Those who insist that hypertension is always caused by renal vascular dis-

ease maintain that these cases without arteriolosclerosis have lesions in larger arteries sufficient to cause renal ischemia. However, sclerosis of large and small renal arteries is present in the majority of nonhypertensive elderly persons, and some of the hypertensive subjects have no disease even of these larger vessels.

I have studied the kidneys microscopically in about 600 persons with diabetes. It is well known that generalized arteriosclerosis is much more severe in elderly persons with diabetes than in persons without diabetes of corresponding age. Renal arteriolosclerosis is also very prominent in persons with diabetes and occurs in nearly half of those with small hearts and systolic pressures below 140 mm. mercury. The incidence of arteriolosclerosis in diabetes with different levels of systolic blood pressure is as follows:

Systolic Blood Pressure	Per cent Arteriolosclerosis
Below 140	49.5%
140 to 149	65.4
150 to 169	72.0
170 to 199	84.5
Above 200	94.6

It is obvious that there is a causal connection between hypertension and renal arteriolosclerosis in diabetes, but it is noteworthy that either condition may exist without the other. Age is a factor of great influence, since renal arteriolosclerosis was found in 31.8 per cent of persons with diabetes under 50 years of age and in 80 per cent of those over 50 years old.

An Age Change

The available data from my studies indicate strongly that renal arteriolosclerosis is primarily an age change in the arteries and that when it develops to a sufficient degree, it usually brings about or intensifies hypertension, but in a great many instances it does not cause hypertension. Typical clinical hypertension may develop in the absence of renal arteriolosclerosis. It appears, therefore, that renal arteriolosclerosis and hypertension may originate independently, but when the vascular lesion becomes severe, it usually causes hypertension.

Hypertension Causes Arteriolosclerosis

The evidence that hypertension causes renal arteriolosclerosis is not convincing. One argument against this view is the frequent absence of arteriolosclerosis in hypertensive disease of long duration. In chronic glomerulonephritis with hypertension for many years, true renal arteriolosclerosis is not often seen. The sclerotic arteries in this disease are usually examples of disuse atrophy. It is clear, however, that hypertension causes lesions in the retinal arteries, since these are not present at first and appear only after the blood pressure has reached high levels. It is easily possible that hypertension hastens the process of sclerosis elsewhere in the vascular system.

Hypertension and Arteriolosclerosis Originate Independently

The theory most consistent with our present information is that hypertension and renal vascular disease may originate independently and that severe vascular renal disease usually causes or intensifies hypertension.

One may believe that the renal vascular lesion in some way causes the liberation of a renal pressor substance, but this view does not explain the cases of hypertension that do not have vascular disease nor does it account for the cases of renal vascular disease without hypertension. It may be that renal arteriolosclerosis is merely an expression of a generalized aging process in the greater part of the peripheral vascular bed which brings about an increase of peripheral resistance.

The Retina

One of the fairly constant features of chronic hypertension is a narrowing of the small retinal arteries and arterioles. Hypertensive retinitis develops in most of the patients in whom a very high blood pressure has been present for some time. Since the blood pressure is nearly always very high in hypertension with uremia, these patients usually have hypertensive retinitis. In chronic glomerulonephritis with high blood

pressure, hypertensive retinitis occurs frequently. The high blood pressure is responsible for the retinal edema and hemorrhages.

The arterioles in the choroid have the same muscular structure as arterioles elsewhere and show the same kind of hyaline intimal disease, but the choroidal vessels are not visible in the eyegrounds. The retinal arterioles, however, contain little or no smooth muscle, and the only visible microscopic change in them is a thickening of the hyaline walls. It is not understood why these vessels appear narrow on ophthalmoscopy.

Hypertension*

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THAT all physicians study many patients with hypertension is not surprising, because this disease ranks first as a cause of death. Hypertension is really a symptom of disease rather than a disease entity, and it is caused by, or associated with, at least fifty-two diseases. The sad fact still remains, however, that hardly more than 3 to 5 per cent of these patients have hypertension other than the essential or malignant variety. True it is that an occasional pheochromocytoma, a Wilm's tumor, or a perinephric lesion is encountered in which specific therapy is available. Occasionally unilateral renal disease is seen early enough to remove the kidney and cause reduction in arterial pressure. But most of the work of the physician is concerned with the great group of patients with essential and malignant hypertension.

Much has been learned about this group in the past twelve years, and, although fully effective and practical therapy has not as yet been achieved, it is difficult to believe that a few more years of research will not materially change the lot of the person with hypertension. For this reason alone, it is worth following the course of the work going on now. One of the fascinations of medicine is that its face is always changing and that each generation participates in or watches the change in its varied manifestations.

Significant Changes in the Field of Hypertension

In the recent past, several changes of the most profound significance have been witnessed in the field of hypertension. It has finally been realized that hypertension serves no very useful function to the body and does not need to be elevated in order to insure efficient renal function, even though the vessels may be narrowed. Nor is it necessary to maintain adequate perfusion of peripheral tissues. Hence, arterial pressure can be lowered without interfering with bodily function. It should not be forgotten that not long ago the opposite was the common teaching.

A second change is the realization that hyperactivity of the nervous system is not the primary cause of arterial hypertension, although it may play an important part. Most research supports the view that a chemical substance liberated by the kidneys elevates the blood pressure. The nervous system undoubtedly mediates the demands of the body for quick changes in blood distribution, but the slow changes are caused by humoral agents. There is good reason also to believe that the nervous system is concerned with the maintenance of the reactivity of the body to humoral agents.

A third change of great importance is the demonstration that while renal excretory function may be normal in persons with hypertension, profound changes in the distribution of the blood within the kidneys have taken place. To define essential hypertension as a condition in which renal function is normal is incorrect, because although renal

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** From the Lilly Laboratory for Clinical Research, Indianapolis City Hospital, Indianapolis.

excretory function is normal, other functions are not.

A fourth change is the elaboration of methods which would accurately reproduce hypertension in animals. The two methods now in common use are the compression of the main renal artery by means of a clamp and the compression of the renal parenchyma by the scar resulting from perinephritis induced by wrapping the kidneys in cellophane or silk. Extensive studies into the mechanism of hypertension have been made possible by these methods, which could not, for the most part, be done in patients.

Fig. 1. Fibrocollagenous hull formed around a kidney as the result of perinephritis induced by cellophane. This animal's mean blood pressure rose to 242 mm. Hg.

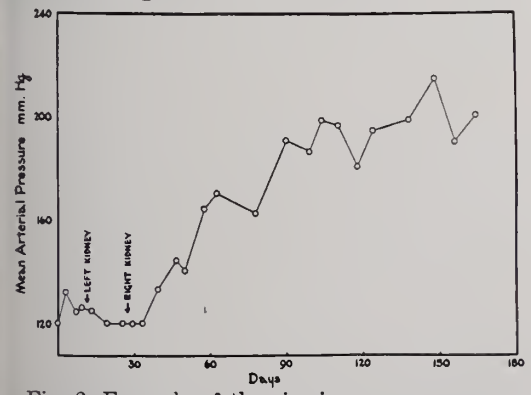

Fig. 2. Example of the rise in mean pressure resulting from application of silk or cellophane to the kidneys of a dog. Somewhat similar rise in blood pressure has been observed in patients in whom pressure is exerted on the kidneys by tumors, etc.

While it is definitely recognized that these profound changes in the fundamentals of hypertension have taken place, much of this knowledge has not been appreciated by clinicians in their thinking, nor has it found application at the bedside.

Views of the Lilly Clinic

Without going deeply into the fundamental investigations involved, I shall present a thumbnail sketch of the views which we at the Lilly Laboratory uphold as to the mechanism of hypertension. Reduction in pulse pressure and, possibly, temporary drop in blood flow may start the renal vasopressor system into action. What change is responsible for this alteration in pulse pressure is not known. An enzyme called "renin" is contained in the renal tubular cells and is liberated into the blood stream. It acts on the $alpha_2$ globulin of the plasma to form a third substance called "angiotonin." The globulin, incidentally, has its origin in the liver. Angiotonin is apparently the substance causing the rise in blood pressure. Note particularly that the rise in blood pressure in all three types of hypertension—essential, experimental, and angiotonin—is of a very special sort. It is characterized by augmentation of the force of the heart beat—hence, the overactivity and enlargement of the heart seen at the bed side. Also characteristic is the constriction of the peripheral arterioles without reduction of blood flow—hence, the skin and muscles are not pale and bloodless. The changes in the kidneys are peculiar and interesting. In short, the principal change seems to be constriction of the small arterioles distal to the glomeruli which results in increased pressure within the glomerulus and reduction of blood flow around the tubules. The clinical result of this, an artificially elevated urea clearance and reduced ability to concentrate urine is a point of considerable clinical usefulness. More recent work shows that the intrarenal hemodynamics can be more accurately investigated by the inulin and diodrast clearances. Suffice it to say that the former measures glomerular filtration and the latter tubular secretion. In view of the changes of blood distribution I have mentioned, it may clarify why these tests have assumed a place of great importance in clinics devoting their time to research on cardio-

Fig. 3. Comparison of the pressor response to angiotonin and renin in a cat with the nervous system destroyed. At signal marks 1, 2, 3, angiotonin was injected, and at 4 and 5, renin. Note the long, slow rise in arterial pressure after renin due to the time required for intra-action of the enzyme renin with the substrate alpha$_2$ globulin.

vascular disease. Perhaps a better term is "angiology," a more inclusive term when one considers that the heart is only a specialized portion of the vascular system.

Treatment Still in Experimental Stage

Treatment of hypertension is still an experiment. Practicing physicians are naturally anxious for practical means of handling hypertensive persons and are sometimes impatient with the ineffective efforts of investigators. Impatience leads to forced conclusions and hasty experimental work, neither of which will contribute to the finding of the truth.

We at the Lilly Clinic believe that when the operation is adequate, sympathectomy has its place in the management of hypertensive patients. The selection of patients requires care and experience. Its good effects are not due to increased blood flow in the kidneys, as has so often been erroneously stated.

Thiocyanate is also a useful drug in our experience, which now comprises some 500 patients. This drug should not be used without chemical control and should not be given merely to be giving something. Some patients do not respond favorably, and its use in those individuals should not be continued.

In our experience, purified renin has not been found capable of lowering blood pressure in dogs or rats with experimental hypertension, even when pellets of renin were implanted. Since we had no success with the use of renin in animals, we have not tried it in human beings. The report of Wakerlin, who states that he is doing this, will be awaited with interest.

We have tried large doses of vitamin A in patients—in fact, double the dose recommended—but have found no change in their blood pressure. We have not tried it in dogs, but Wakerlin recently stated that it lowered blood pressure in dogs with experimental hypertension much as did renin in his experiments on that subject.

We have had no experience with tyrosinase. Schroeder thinks that it reduces blood pressure because of the enzymes in the solution. Apparently others think this also, while still others consider the results purely a result of impurities other than tyrosinase.

So-Called "Nonspecific" Therapy

So-called "nonspecific" therapy has been used for many years with occasional good results. The term itself is almost meaningless and might well be dropped, but its use is so current that this would be difficult. Typhoid vaccine given intravenously to patients with renal disease may cause serious loss of renal function. We doubt that it should be given by vein at all as a therapeutic measure to patients with renal disease. Scott has recently claimed that results quite as good as observed with kidney extract can be obtained with milk injections. It will take several years of research before we ourselves shall reach any sound opinion on this observation. If it works, it will be a godsend.

There is good physiologic evidence to suggest that the kidneys contain an antipressor agent; hence, the search for it. To date it has been shown that kidney extracts of special sorts can lower blood pressure, reverse many of the retinal changes of the malignant syndrome, and alter the changes in distribution of blood within the kidney towards normal. I have no idea how kidney extracts work now, whether they are "specific" or "nonspecific." At present we are working in line with the theory that an enzyme, angiotonase, which is present in large amounts in some of these extracts, is the active agent. We do not know whether or not this is true.

We have had, perforce, to change our work for the most part from hypertension to its counterpart, hypotension and shock. Perhaps in the long run this will broaden our perspective, for, in the last analysis, the problem of hypertension, just as the problem of shock, is part of the great problem of blood distribution.

Evaluation of the Modern Concept of Hypertension and Its Therapeutic Implications*

By FRANCIS D. MURPHY, M. D.**
Milwaukee

ALTHOUGH clinical investigation and experimental research have amplified our knowledge of hypertension, prominent advances in the therapy of hypertensive patients have not been forthcoming. This does not mean that there has been no genuine progress but rather that the therapeutic achievements so far have not compared with the hopes engendered by scientific discoveries. When we are faced with the responsibility of treating a patient with hypertension, we are compelled to resort largely to the chief empiric methods of therapy which are generally known and usually useless.

In this article, I shall discuss the various methods of treatment of hypertension and review the relation between diseases of the kidney and hypertension. Such an evaluation requires, first, a differentiation of the various kinds of hypertension and especially of the clinical conditions recognized as benign and malignant hypertension; secondly, a survey of our modern concepts of hypertension; and, finally, an appreciation of forms of treatment now being employed. Obviously this can be done only in an epitomized form.

Past Concept of Hypertension

Until recently, patients with clinical hypertension were classified into two large groups: the renal group and the nonrenal or essential. The so-called renal forms included particularly chronic glomerulonephritis; the essential types generally constituted arteriosclerosis. Later on, the renal group was broadened to include not only glomerulonephritis but also pyelonephritis, and essential hypertension was separated into the benign and malignant forms. In the renal group, the kidney held the center of the stage. Heavy albuminuria, red blood cells, white blood cells, and casts in the urine were the chief features, while in essential hypertension, the role of the kidney was not impressive but, instead, the heart seemed to be the organ chiefly at fault.

When the differentiation was made between nephritic and essential hypertension, a great advance in our knowledge of the relationship between the kidney and high blood pressure seemed to be accomplished. In nephritic hypertension, the kidney plays the outstanding role. The heavy albuminuria, red cells, white cells, and casts identify the kidney in a positive way. The patient is generally under 40 years of age but may be older. There is usually a history of some kidney difficulty with albumin in the urine dur-

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ing the adolescent period. The hypertension need not be exceedingly high, and the associated syndromes, as edema and evidences of renal insufficiency, help to distinguish this kind of hypertension from the essential type. Furthermore, the patient with nephritic hypertension is likely to undergo periods of remission which last for a month or two or a year or two. The duration of life is usually short, averaging five to ten years. Renal failure, gradually becoming more disabling, finally terminates in uremia and closes the comparatively short course of nephritic hypertension. Although chronic glomerulonephritis is the chief kidney disease involved in so-called renal hypertension, others must always be taken into consideration. Conditions such as stones, cysts, and tumors of the kidney may cause hypertension. Although these conditions are rare compared to nephritis, the surgical removal of them sometimes cures the patient of hypertension. Comparative studies have been made, and, while unanimity of opinion does not exist, the general view is that instances of cures of hypertension by surgical removal of a diseased kidney are rare.

Essential Hypertension

Contrary to this picture, essential hypertension is recognized by an entirely different course. One of the chief advances in our knowledge of hypertension came when essential hypertension was separated into the benign and malignant forms. Since approximately 90 per cent of these cases of essential hypertension are designated as benign and only 10 per cent as malignant, it is common practice in some places to consider the benign form to be essential hypertension.

While the kidney plays the predominant role in the hypertension of nephritis, the heart is the organ chiefly at fault in essential hypertension. Benign (essential) hypertension is recognized by high blood pressure, cardiac enlargement, and an asymptomatic course. The critical course is placid, slow, and painless; heart failure of a chronic type lies at the end of the road in most cases, but occasionally apoplexy or uremia terminates the disease. In sharp contrast to the hypertension of the nephritic group, the kidney appears to be innocent; a trace of albumin in the urine is sometimes all that is found. Renal function tests reveal normal capacity. There is no history of kidney trouble during adolescence. The patient as a rule is over 40 years of age. The height of the blood pressure is all out of proportion to the other features. There may be a blood pressure of 230:120, and yet symptoms may be lacking. Periods of relapse and remission, as seen in nephritis, do not occur. The patient with this kind of hypertension carries a high blood pressure for a period of ten to fifteen years before he becomes aware of any discomfort. Then headache, shortness of wind, pain in the chest, or a feeling of general malaise may compel him to seek medical advice. Chronic heart failure usually sets in then, and this patient struggles along for another four to five years until death occurs.

Malignant Hypertension

The other subdivision of hypertension, known popularly as malignant hypertension, is not really a separate and distinct disease but merely a phase of essential hypertension. It differs from the benign form only in degree of severity, speed of progress, and ultimate outcome. Both benign and malignant types are associated with arteriosclerosis of the renal arteries and arterioles, but in the malignant type, the arteriosclerotic process is more widespread and is distinguished further by the presence of necrotic lesions throughout the arterioles of the kidney.

Clinically, malignant hypertension occurs in young people, often in their thirties or even younger. The blood pressure, which has been elevated for some months, suddenly becomes fixed at a higher level, and the following sequence of events takes place: 1. Headaches are severe and almost unbearable. 2. Diastolic pressure mounts to 130 to 150 mm. Hg. 3. There is rapid loss of weight and appetite, and vomiting frequently develops. 4. One of the outstanding identification marks of malignant hypertension is bilaterial choking of the disks; fresh and old white patches are scattered throughout the retina, and new and old hemorrhages, large and small, are present. The edema of the retina is so great that the constricted blood-

less arterioles may be entirely obscured. 5. There is a perceptible deterioration of health, and after a stormy course of one to two years, this very sick individual often dies abruptly of uremia.

Modern Concept of Essential Hypertension

The modern concept of essential hypertension is based upon the animal experimental work of Goldblatt and his colleagues[1] and of Page and his associates[2] and on the observations of subsequent investigators. As this work has been reviewed many times, no detailed discussion is necessary now.

Our understanding of the role of the kidney and the genesis of essential hypertension is taken from Page's work[3] and may be epitomized as follows: The normal kidney contains a substance designated "renin." Renin alone cannot cause hypertension, but if it is allowed to interact with another substance in the blood known as "renin activator," a third substance called "angiotonin," which contains qualities enabling it to raise blood pressure, is formed. Next it has been postulated that the normal kidney also contains an inhibitor substance. While our knowledge or such an antipressor substance is not as definite as that of the pressor substance, there is strong evidence that such an inhibitor is present. Although there is no positive proof, cogent evidence of the existence of such an antipressor has been given in detail by Page.

These epoch-making observations have provided a scientific explanation for the occurrence of hypertension in dogs and in some humans, but the tendency to believe that all hypertension, especially all cases of essential hypertension, is due to the same mechanism is not accepted by all. The change in the hemodynamics, which is considered the main event in the genesis of hypertension, is difficult to visualize in patients with early essential hypertension. The complete acceptance of such an explanation for all cases of essential hypertension is prevented by one main stumbling block; that is, in the very early stages of some cases of essential hypertension, arteriosclerosis of the kidney arterioles is barely perceptible. We are asked to accept the fact that essential hypertension is caused by an arteriolosclerosis of the kidney and at the same time to believe that essential hypertension causes arteriosclerosis. It is also well accepted that the more severe the hypertension, the greater the degree of arteriosclerosis. If arteriosclerosis of the kidney in patients with hypertension is the result of hypertension, it is difficult to convince us that it is also a cause. It may be that the earlier stage in change of hemodynamics is caused by a spasm of blood vessels rather than by arteriosclerosis.

Surgical Intervention

The treatment of essential hypertension may be classed into the surgical, the medical, and the kidney extract therapy. A summary of the surgical may be given as follows: There are several different types of operations on the autonomic nervous system for hypertension that differ considerably with the extensiveness of operation, but all of them are distinctly in the class of major operations. While these surgical procedures have been used in a large number of cases by neurosurgeons with special training, sufficient time has not elapsed to give unqualified endorsement to this type of treatment. The general opinion is that operation offers certain select patients the best chance of recovery. Further careful study of patients must eventually be done before the final answer is forthcoming.

Medical Treatment

During the last ten years, several papers have been published delineating the common methods of drug treatment of hypertension. All of them, including Mosenthal's[4] most recent article, conclude that there is no drug which is satisfactory in the control of hypertension. Thus far, potassium thiocyanate, when used in such a way that the optimal concentration in the blood is maintained, offers the most effective treatment. The sedatives have their place but are not specific. Choline derivatives have been used, but the effects on hypertension have been disappointing.

Of the various vitamin preparations suggested, the most recent one in the treatment of renal hypertension is vitamin A. Favorable results in treatment of essential hypertension have been achieved with large

doses of vitamin A orally.[5] Five dogs were rendered hypertensive by the Goldblatt technic, and the resulting hypertension was permitted to stabilize over a period of five to eight months. Two hundred thousand units of vitamin A dissolved in 1 cc. of sesame oil were given by mouth daily for three months to three dogs. This was followed by 400,000 units of vitamin A in 2 cc. of sesame oil for an additional three months. Two other dogs serving as controls received oral daily doses of 1 cc. of sesame oil for three months, followed by 2 cc. of sesame oil for another three months.

A striking reduction in blood pressure was observed in each of the three dogs. The mechanism involved in the reduction in the blood pressures of these three renal hypertensive dogs by large doses of vitamin A is obscure. Since the vitamin A preparation used contained traces of impurities, it is possible that one or more of these impurities was responsible for the reduction in blood pressure; therefore, more experimentation must be done. We propose to enlarge considerably this preliminary study of vitamin A in experimental renal hypertension and also to determine the possible antihypertensive effects of other compounds chemically related to vitamin A.

Kidney Extract Therapy

The use of kidney extract in the treatment of hypertension was reported some years back, but such extracts were employed on an empiric basis and apparently were used with the idea that if the kidney was at fault, the extract might contain a substance that would be of benefit. The kidney extract therapy used by Page,[6] Grollman and his associates,[7] and by ourselves[8] has been done on the assumption that angiotonin, as described by Page, is inhibited in its activity by a renal extract. Just how kidney extract inactivates angiotonin or destroys renin or renin activator or how it brings down blood pressure is not entirely clear at the present time. There are some responsible observers who have stated that the extracts as made today are inactive and that any blood pressure reducing effects come from known specific action or from pyrogens. On the other hand, other capable investigators have found kidney extracts to have blood pressure reducing qualities.

Our experience with the kidney extracts has been based on a two years' observation. We have treated 16 patients with kidney extract; of these, 6 improved (2 with malignant hypertension, and 3 with benign), 4 showed no improvement (1 malignant, 3 benign), and 6 died (5 malignant, 1 benign).

BIBLIOGRAPHY

1. Goldblatt, Harry: Experimental Hypertension Induced by Renal Ischemia, The Harvey Lectures, Series 33, 1937–38, p. 237.
2. Page, I. H.: A Method for Producing Persistent Hypertension by Cellophane, Science 89:273 (March 24) 1939.
3. Page, I. H., and Helmer, O. M.: A Crystalline Pressor Substance (Angiotonin) Resulting from the Reaction between Renin and Renin-Activator, J. Exper. Med. 71:29 (Jan. 1) 1940.
4. Mosenthal, H. O.: Relation of Kidney to Blood Pressure, New York State J. Med. 41:953 (May 1) 1941.
5. Wakerlin, G. E.; Moss, W. G., and Smith, E. L.: Treatment of Experimental Renal Hypertension with Vitamin A, Science 96:161 (Aug. 14) 1942.
6. Page, I. H., and others: Reduction of Arterial Blood Pressure of Hypertensive Patients and Animals with Extracts of Kidneys, J. Exper. Med. 73:7 (Jan. 1) 1941.
7. Grollman, A.; Williams, J. R., Jr., and Harrison, T. R.: Reduction of Eelevated Blood Pressure by Administration of Renal Extracts, J.A.M.A. 115: 1169 (Oct. 5) 1940.
8. Murphy, F. D., and others: The Use of Kidney Extracts in the Treatment of Hypertension in Experimental Animals and Patients, Proc. Central Soc. Clin. Research, vol. 14 (Nov.) 1941.

To help the Medical and Surgical Relief Committee of America continue its vital work of providing emergency medical kits to Coast Guard patrol boats and Navy subchasers, an urgent appeal for drugs and instruments has been issued by the Committee to surgeons, physicians, and medical supply houses.

Among the items sorely needed to equip the emergency kits are artery clamps, splinter forceps, scalpels, probes, grooved directors, sulfadiazine tablets, sulfadiazine ointment 5 per cent, sulfathiazole tablets, and sterile shaker envelopes of crystalline sulfanilamide. Any other spare medicines or surgical instruments are, of course, equally welcome.

Please send your contributions to: Medical and Surgical Relief Committee of America, 420 Lexington Avenue, New York, N. Y.

A Logical Approach to the Diagnosis of Heart Disease*

By ARLIE R. BARNES, M. D.**
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THE diagnosis of heart disease is looked upon many times as a difficult problem. Specialists known as "cardiologists" have equipped themselves extensively with electrocardiographs and roentgen-ray equipment. As a result, a false impression has arisen that these adjuncts are indispensable in the diagnosis of cardiac disease. As a matter of fact, without such help it is possible in most instances to arrive at a satisfactory estimate of the kind and degree of cardiac damage by resort to the ordinary methods of taking a history and making a physical examination.

In medical teaching, an atmosphere of complexity on the subject of heart disease has been created. To some extent, the simple fundamental principles have been overlooked. It is the object of this paper to bring simplicity to the subject and to restore the confidence of physicians in their ability to arrive at a diagnosis with the aid of their senses. Even the subject of murmurs has been excessively belabored with elaborate descriptions of the qualities of a murmur and the direction of its transmission, so that physicians have come to feel that without the most minute knowledge of murmurs they are lost. Actually, there are only two murmurs that are diagnostic of valvular defects: the diastolic murmur of aortic regurgitation and the presystolic murmur of mitral stenosis. No amount of description can teach the physician to recognize the quality, time, and pitch of a murmur; the only way he can learn it is to hear it.

Classification by Etiology

Heart disease can be classified in a few simple groups on the basis of etiology. The largest group consists of the degenerative heart diseases due to coronary sclerosis, essential hypertension, or hypertension of the pulmonary circulation, the most common cause of which is asthma or asthmatic bronchitis with associated emphysema. The second most important cause of heart disease is rheumatic fever. Syphilis accounts for much cardiac damage, but, fortunately, this type of heart disease is very much less common than it was twenty years ago. Hyperthyroidism, also less common than it was fifteen years ago, still is responsible for the precipitation of much heart failure but usually can be remedied by surgical operation. Congenital defects of the heart are infrequently encountered. Although in most instances little can be done about them, yet some types are amenable to surgical correction. Fortunately, these defects constitute only a small percentage of cardiac disturbances.

Obviously, then, the first task is to take a careful history, so that it may be determined what antecedent events or conditions were capable of producing cardiac disease. Does the patient give a history of rheumatic fever or of syphilis? Is there a history of anginal pain? Has the patient been rejected for life insurance in the past ten years because of hypertension? Is there a history of long-standing bronchitis with asthmatic manifestations? Was the patient a "blue baby," was a murmur observed in the first year or two of his life, and was his growth and tolerance of exercise less than those of his playmates in the first six years of childhood? Before starting to examine a patient, the physician should have a clear picture of all the factors in the previous life of the patient which could lead to heart disease.

Pathology of Rheumatic Fever

The physician's next step in his diagnosis of heart disease is the use of his knowledge of pathology. Suppose that the patient gives

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a history of rheumatic fever. What pathologic picture then presents itself? A lesion is visualized which has its inception generally when the patient is between the ages of 5 and 15 years and only occasionally after the patient has attained the age of 30 years. Few patients succumb to an acute attack of rheumatic fever or even to the first few exacerbations, although the latter often precipitate attacks of heart failure. The disease goes on to the chronic development, consisting of recurring acute and subacute attacks of rheumatic fever which lead to gradual cicatricial narrowing of the orifices of the valves, to true myocarditis, and to pericardial involvement. Rheumatic heart disease occurs more frequently among women than men, in about the ratio of 5:4. Only the mitral valve is involved in about 40 per cent of the cases; only the aortic valve, in about 18 to 20 per cent; and the aortic and mitral valves together, in 30 per cent. In an additional 5 per cent of the cases, the tricuspid valve is involved in conjunction with disease of both the aortic and mitral valves. Involvement of only the mitral valve occurs twice as commonly among women as among men. Few patients who have rheumatic mitral endocarditis escape symptoms of heart failure beyond the age of 40 years. Aortic involvement in rheumatic fever may produce aortic regurgitation, particularly in the early stages of rheumatic fever; but cicatricial changes occurring in the aortic valve tend to convert the aortic insufficiency into aortic stenosis, which is a fortunate event in relation to prognosis. Aortic stenosis, a rheumatic lesion encountered three or four times more frequently among men than among women, is consistent with freedom from cardiac symptoms for a much longer period of time than is mitral stenosis. Aortic stenosis often is overlooked or is believed to be caused by aortic sclerosis. If it is coupled with the loss of the second aortic sound because of rigidity of the aortic leaflets, or if it is associated with a basal systolic thrill, a rough systolic murmur over the aortic area suffices to make the diagnosis. Further confirmation of the diagnosis may be obtained by visualizing the calcified aortic leaflets on roentgenoscopy. And, finally, in projecting the pathologic possibilities in a case of rheumatic fever, it must always be borne in mind that chronic endocarditis is commonly the soil in which subacute bacterial endocarditis is planted.

Pathology of Syphilis

Suppose that the patient gives a history of having had syphilis. What pathologic changes in the heart may be encountered? First of all, syphilitic aortitis is more common among men than women. There is a latent period of about twenty years from the time of the initial lesion of syphilis until signs and symptoms referable to the heart appear which lead to the diagnosis of aortic involvement. This means that syphilitic heart disease usually will be discovered in or near the fifth decade of the patient's life, reckoning from the usual age of indiscretion. Syphilis of the heart is confined practically to involvement of the aorta. It may lead to aortic regurgitation, aortic aneurysm, or to narrowing or closure of the mouths of the coronary ostia. In the latter case, symptoms of angina pectoris may appear. If the aortic ring is involved, the ring is enlarged, the commissures are widened, and the free edges of the valve leaflets are rolled and often become adherent to the adjacent aortic wall. Such a process leads to aortic regurgitation but never to aortic stenosis, a fact worthy of emphasis. Left ventricular hypertrophy and eventually left ventricular failure are the ultimate consequences of the aortic regurgitation which ensues.

The pathology of uncomplicated hypertension is quite simple. It consists of increasing hypertrophy and, eventually, dilatation and failure of the left ventricle. Failure of the left ventricle produces pulmonary hypertension, which in turn leads to hypertrophy and eventual failure of the right ventricle. Very commonly, varying degrees of coronary sclerosis accompany hypertension, and, if such sclerosis is advanced, it may dominate the clinical picture and constitute the cause of death.

Insufficiency of the coronary arteries may have widely varied pathologic characteris-

tics. Symptoms of anginal pain and even sudden death may be associated with degrees of coronary atherosclerosis varying from moderate to almost complete obliteration of the lumens of the coronary vessels. Gradual occlusion of one or more coronary vessels may occur without myocardial infarction, although, more commonly, patchy myocardial fibrosis will be observed. Acute coronary occlusion regularly leads to acute myocardial infarction. Acute myocardial infarction can occur in the presence of coronary sclerosis without coronary occlusion, particularly when shock, marked sepsis, and hypertension are present concomitantly. Most observers doubt that coronary sclerosis alone leads to cardiac hypertrophy.

Chronic cor pulmonale is characterized by gradual hypertrophy of the right ventricle and eventually by dilatation of the pulmonary conus and dilatation and failure of the right ventricle. It is the most difficult of all cardiac lesions to identify but may be suspected if other sources of cardiac damage are eliminated on the basis of the history and results of the physical examination. A history of asthma or asthmatic bronchitis or the finding of pulmonary emphysema is the common background for pulmonary hypertension and damage to the right ventricle. Acute cor pulmonale, which is due to pulmonary embolism, produces acute dilatation of the right ventricle and pulmonary conus.

Pathology of Hyperthyroidism

Although hyperthyroidism, when it is uncomplicated, seldom leads to heart failure, nevertheless it is a common factor precipitating heart failure in hearts handicapped by some existing cardiac pathologic process. If a patient who has heart failure exhibits loss of weight, excessive sweating, quadriceps weakness, tremor of the hands, or ophthalmic signs suggestive of exophthalmic goiter, the condition of hyperthyroidism must be considered. When these symptoms are present and when palpable enlargement of the thyroid gland is not, no examination of a patient suffering from heart failure can be regarded as fully complete until the possibility of substernal adenoma of the thyroid has been excluded by roentgenology. Unexplained auricular fibrillation or flutter calls for the careful exclusion of hyperthyroidism as its cause. The character of the pathologic process in patients who have hyperthyroidism will depend largely on the kind and degree of the underlying concomitant heart disease. If a heart is already diseased, hyperthyroidism may produce dilatation and failure of one or both ventricles. Except for this, the heart muscle shows little or no change directly attributable to the presence of the toxic stage of hyperthyroidism.

It is beyond the scope of this paper to discuss the pathology of congenital heart disease. The history of cyanosis at birth, the discovery of a murmur in the early years of the patient's life, and the observation of peculiar, machinery-like murmurs usually will suffice to indicate a congenital cardiac defect. Since at least one congenital cardiac defect is amenable to surgical intervention, this is one instance in which special diagnostic aids and the services of a specialist may be required. In general, however, no treatment is effective except the usual regimen of restricted living, so that the distinction of these defects is not so important.

Pathology of Constrictive Pericarditis

Another cardiac disturbance of uncertain etiology, whose recognition is important because its surgical treatment is followed by such spectacular results, is the condition known as "constrictive pericarditis." In this condition, the heart is enveloped by a constricting fibrous or calcareous covering. The heart may not be enlarged or may be only moderately so, and, commonly, no murmurs are present to suggest heart disease. If edema, ascites, and slight cyanosis have developed gradually, and if in the presence of the cardiac pathologic process and physical observations just mentioned the venous pressure is abnormally high, the chance that the physician is dealing with constrictive pericarditis is great. The diagnosis can be confirmed if calcification of the pericardium can be demonstrated by the roentgenogram or if certain electrocardiographic changes are demonstrated.

Value of Pathologic Approach in Diagnosis

Consider how this approach to the diagnosis of heart disease functions in actual practice. If the patient is a man between the ages of 35 and 50 years and is known to have syphilis, the physician must look for signs of aortic insufficiency, for atresia or occlusion of the coronary ostia, usually evidenced by the anginal syndrome, or for evidences of aortic aneurysm. Aortic stenosis never arises from this cause. If the patient is a woman who gives a history of rheumatic fever, the physician can expect to find mitral stenosis commonly and aortic stenosis rarely. In a man who has had rheumatic fever, aortic stenosis will be found commonly, either alone or in combination with mitral endocarditis. If the patient was a "blue baby," if his tolerance of exercise was less than that of his playmates, or if his growth was retarded, the physician must be prepared to interpret murmurs in terms of congenital heart disease. The diagnosis of coronary disease is based chiefly on the history of the patient's symptoms and, to a very minor degree, on physical observations. Hypertensive heart disease is characterized by the finding of displacement of the apex outward and downward in association with hypertension, present or past. The role of hyperthyroidism in the production of heart disease is disclosed by the symptoms and observations indicative of hyperthyroidism.

Familiarity with these fundamental facts is the simple, direct, and logical approach to the diagnosis of heart disease. With this knowledge at his finger tips, the practitioner can actually form a fairly accurate estimate of the cardiac pathology that will be encountered before the physical examination is undertaken. With this background, he will be in a position to understand and evaluate murmurs with the least possible confusion and can approach the diagnosis of heart disease with satisfaction and confidence.

Rocky Mountain Spotted Fever

By BEAUFORD I. PIPPIN, M. D., RICHARD E. HOUSNER, M. D. and GEORGE PARKE, JR., M. D.*

Richland Center

THE June, 1942, issue of *The Reader's Digest* reported Wisconsin as one of the few states remaining free from spotted fever. During the month of May, 1942, we were treating what appears to be the first proven case in our state.

Credit goes to Dr. George Hammes, Seneca, Wisconsin, who first saw this patient, made a tentative diagnosis and referred her to us for further study and care. Considerable assistance from our State Laboratory, from R. P. Parker, Hamilton, Montana, and from N. H. Topping of the United States Public Health Service, Bethesda, Maryland, has been available to us. With their help, we are confident that our diagnosis and advice are correct.

* Members of the Pippin Clinic, Richland Center.

Case Report

History

The patient, Mrs. M. C., white, age 53, had nothing unusual in her past medical history. On May 27, 1942, she developed a severe headache, malaise, and generalized pains. She had a sense of severe pressure on the top of her head. Aspirin would give her relief for short intervals only. On May 29, she sought medical aid.

Physical examination revealed a well developed, well nourished, white woman. She appeared uncomfortable and very restless. Her skin was hot and dry. There was a raised, red areola, one inch in diameter, on the nape of her neck where she had removed a large engorged wood tick on May 21, 1942. She complained of soreness in this area. Her tongue was furred, and petechial hemorrhages were present on the posterior portion of the palate. Her chest was clear; respirations, 22 per minute; heart, normal; blood pressure, 132:80; pulse, 130, of good quality

and regular; temperature, 102.8 F.; urine, negative; neurologic examination, within normal limits except for the extremely restless state. There were small red areas about .5 cm. in diameter on both arms and legs. They were maculopapular and not tender. The eruption was petechial in nature.

Ten days prior to removal of the tick from her neck, cattle from Iowa had been purchased and moved to this farm. Known cases of spotted fever have been reported from Iowa.

She was given 15 grains sulfathiazole every four hours and sedation. On May 31, 1942, there was no improvement and no response to treatment. She was brought to our hospital. Her temperature was 102.4 F. She was delirious and very toxic, complained severely of generalized pain, and had developed a sharp hacking cough. The chest roentgenray was normal. The eruption had spread over the entire body. Many areas had coalesced and were seen on both the palms of the hands and soles of the feet. They did not disappear upon pressure. Chills occurred about three times daily. The conjunctivae were inflamed, and epiphora was present. The throat and the pharynx were clear. The chest was clear and the heart rapid but not enlarged. The liver and spleen were not palpable. The abdomen was soft with no masses. The skin was hot and dry.

Laboratory Tests

The urine was essentially negative. The blood picture was as follows:

RBC	4,010,000	Differential: Stabs	17
WBC	5,600	Segs	62
Hg.	80%	Monos	2
		Baso	2
		Lymphs	27

Repeated complete blood counts revealed little change until the temperature became normal on the fourteenth day, when the stabs dropped to eight.

Agglutination tests were done and results follow:

Proteus agglutination O–X–19 negative; O–X–2 negative.
Undulant fever—negative.
Typhoid—negative.
Tularemia—questionable.

The temperature ranged between 101 F. to 103.4 F. for twelve days. Prominence of the rash followed the temperature curve. When the temperature became normal, few spots were present, but when the temperature rose, even as little as one degree, numerous additional eruptions were found.

The patient was discharged twenty-one days after onset of her illness. The only remaining symptom was the disturbed nervous system. Orientation was difficult at times, but this condition rapidly corrected itself when the patient returned home.

Three tests for Rocky Mountain Spotted Fever can be made. These are as follows:

"A. *Agglutination Test* (Weil–Felix reaction) three samples desirable:

1st—*taken soon after onset*—is usually negative but is needed to check with results from later samples.

2nd—*taken between 10th and 15th days*—often positive, particularly if results of first sample are at hand for comparison, but titer is sometimes too low to be significant.

3rd—*taken during early convalescence*—usually definitely positive, but results of earlier tests may be needed for comparison.

Occasionally a positive test is not obtained until thirty days after onset or even later.

"B. *Infection Test.* The clot from blood samples sent for agglutination tests is injected into guinea pigs wherever possible. If a sample has been in the mail for less than twenty-four hours, infection is often recovered in the test animal. This test is sometimes of differential value.

"C. *Protection or Virus-Neutralization Test* using convalescent blood. Constant amounts of serum are mixed with graded amounts of virus and tested in guinea pigs for protective value. This test is usually quite specific and can be used if the other tests are inconclusive or have not been made."[1]

The results of the protection or virus-neutralization test on this patient are charted below. Guinea pigs are very susceptible to Rocky Mountain Spotted Fever and, when injected with the blood of a patient acutely ill, commonly show a diagnostic reaction. The infection is produced by intraperitoneal injection into the posterior portion of the abdomen. Male animals are used because of the characteristic scrotal reaction which occurs. With protective serum, all guinea pigs lived; without protective serum, all died.

[1] Parker, R. P.: Rocky Mountain Laboratory Bulletin, Hamilton, Montana, (May) 1941, and (July 21) 1937—and Circular No. 478, United States Department of Agriculture.

BLOOD SAMPLE

Date taken—June 12, 1942
Days after onset—19
Days after fever—?
Serum virus— #1682

PROTECTION TEST

S. F. Serum— # A 293
Date Tested—7-17-42

Patient—Mrs. M. D.
Physician—Dr. B. I. Pippin
Address—Richland Center, Wisconsin

	.5 cc. serum B28986 cent. temp.	5 cc. virus 987	.5 cc. serum 988 cent. temp.	serum .25 cc. virus 989	.5 cc. serum 990 cent. temp.	serum 1 cc. virus 991
7-18	38.8	39.2	39.0	39.0	39.2	39.0
	39.0	.0	38.8	.0	.0	38.8
	39.0	.6	39.8	.0	.0	39.0
	40.6	.6	.6	38.6	.4	.4
	39.2	.2	39.8	39.4	.0	.6
	.0	.0	.4	.0	38.8	.6
	.2	.2	.4	.0	.6	.4
	.0	.2	39.8	.2	39.2	.6
	.0	.0	.6	.0	.4	.4
	.2	.2	.2	.2	.4	.2
	.2	.0	.2	.0	.0	.0
	.2	.2	.0	.0	.4	.2
	40.6	.2	.2	38.6	.0	.0
7-31	40.8	.0	.0	.6	38.8	.2

CONTROL TEST

Controls, spotted fever serum virus #1682. Date: 7-17-42.

	.5 cc. virus B28997 cent. temp.	998	.25 cc. virus 999 cent. temp.	29000	.1 cc. virus 29001 cent. temp.	29002
7-18	39.2	39.0	39.0	39.2	39.0	38.8
	.0	38.8	.0	.0	.0	39.0
	.0	39.6	.0	.2	.2	.0
	40.0	.6	.0	.0	.2	.4
	40.4 SF	.0	40.8	.6	.6	41.0
	41.0 SF	.0	41.0	.2	.4	41.0
	41.0 SF	.6	41.0	.0	40.4	41.0
	41.0 SF	.6	40.8	.2	40.8	40.6
	40.6 SF	.8	40.6 SF	.0	40.8	40.6
	40.4 SF	.4	40.6 SF	.2	40.6 SF	40.8 SF
	39.0 S+	.6	40.6 SF	.2	41.0 SF	41.0 SF
	DEAD	.2	40.0	.0	40.6 SF	40.2 SF
	apl x 1½	.0	DEAD	.0	40.4 SF	40.0 +
	3-3-3	.0	apl x 1+	.0	40.2 SF	DEAD
	Consol. areas in lungs		2-3-3			apl x 1+ 3-3-3

Discussion

The eastern dog tick (Dermacentor variabilis) carries the Rickettsia bodies (Dermacentroxenus rickettsii) in the cytoplasm and nuclei of its blood cells. The bite of the tick is charactertistic. The tick may bury its head in the skin of its host and feed on its host's blood until its body takes on massive proportion. The skin area around the bite becomes slightly elevated and markedly erythematous. The areola in this case measured one inch in diameter. As days passed, the bitten area turned a deep purple color and faded to a dark brown which persisted for many weeks.

Experienced northern woodsmen tell us that the tick should never be pulled out. When a tick has buried its head in its host's skin, such a procedure would sever the body from the head and leave the head in situ. We are told that a better procedure is to apply a little heat from a burning match or cigarette to the body of the tick. The tick's interest wil be diverted so that the tick will loosen its hold and then can be gently turned or screwed out rather than pulled directly. A little turpentine or kerosene is also claimed to be effective in loosening the tick. This precautionary measure is advisable, because violent infection will ensue should the head be left. The head may need to be removed if sloughing does not occur.

The tick should not be destroyed but should be kept in a suitable container. If that tick is infected, it may be used to confirm the

diagnosis in your patient. Properly prepared, the tick may be injected intraperitoneally into a guinea pig. A characteristic scrotal reaction appears which is an early diagnostic aid.

The incubation period in this case was more than six days. The characteristic clinical features were manifested by fever (103.4 F.), violent chills, and generalized aches and pains. During the chill and subsequent elevation of temperature, the patient was delirious. This recurred three times every twenty-four hours for a period of ten days.

A maculopapular erythematous rash with a hemorrhagic center appeared first on the wrists and ankles on the eighth to twelfth day after the tick bite. With subsequent chills and fever, a new crop of lesions appeared, gradually extending to other portions of the body; however, they remained more marked on the extremities than elsewhere. Of special significance is the fact that the rash involved the palms, soles, and mucous membranes. The rash did not fade on digital pressure. The older lesions gradually became dark purple, then brown, and remained noticeably pigmented for several weeks.

The course was exceedingly stormy for twelve days; in fact, on several occasions, death seemed imminent. After a twenty-one day illness, the temperature returned to normal by lysis.

The diagnosis is affected by the following:

(1) A history of a tick bite.
(2) The ensuing clinical picture.
(3) Proper laboratory procedures.

There is no positive laboratory method available to establish an *early* diagnosis of Rocky Mountain Spotted Fever. A positive O–X–19 reaction is seldom obtained until after the tenth day of illness or occasionally not until convalescence. The earlier higher titer of the O–X–2 became positive in the higher dilutions (1:640) as convalescence approached. At this point the protection test or the virus-neutralization test became of value. This test definitely establishes the diagnosis.

Two weeks later a patient was examined who presented a typical clinical picture of Rocky Mountain Spotted Fever but with insufficiently high titer to give positive supportive laboratory evidence. However, because the protection test was negative in this case, and the authorities therefor concluded that this patient did not have Rocky Mountain Spotted Fever, he was not included in this report.

Conclusions

1. Rocky Mountain Spotted Fever has come to Wisconsin.

2. The tick carrier is widely known in Iowa and Wisconsin, but these states are not widely infested. The dog is the preferred host.

3. Vaccination against Spotted Fever is feasible if one plans to live in infested territories.

The report of this case has been purposely delayed until the spring months. Thus, the picture and methods of diagnosis will be vivid at a time when the disease becomes most prevalent.

FREE SUPPLEMEMT TO U. S. P. XII

Notice is hereby given to owners of all copies of the U. S. P. XII to fill in and mail the post card order which is tipped inside the back cover of the U. S. P. XII and which entitles the holder to a copy of the First U. S. P. XII Bound Supplement soon to be issued. It was not expected that this Supplement would be issued until about two and one half years after the appearance of the U. S. P. XII, but changing conditions and wartime demands have necessitated its immediate publication. The Supplement itself will carry a similar order form for a Second Bound Supplement, should the latter be required before the appearance of the U. S. P. XIII.

It is expected that the First U. S. P. XII Bound Supplement will be available within one month, and, when it becomes available, immediate shipment will be made without further cost to those who mail in their order cards as directed.

Comments on Treatment

Editors—A. J. QUICK, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Estrogens in Premature Infants

It is a well established fact that the premature infant has severe handicaps in its struggle for life. Many of these physiologic deficiencies are recognized and successfully counteracted. Thus, the lack of temperature control is handled by external heat, with particular care to maintain the humidity at 65 per cent; the low resistance to infection, by the routine aseptic precautions. Likewise, the potential danger of respiratory failure is guarded against by the readiness to give a 5 per cent carbon dioxide oxygen mixture either by funnel or by nasal catheter. The recognition of the fact that the food requirement of the premature infant is high, but that its digestive capacity is low, has led to special care in feeding. Usually, fortified breast milk or one of the recognized commercial products is used, and some physicians follow the rule that the daily fluid intake should equal about one-sixth of the body weight.

But, in spite of all these measures, some premature babies fail to do well, and the urgency to find additional aids arises. As far back as 1927, Aschheim suggested that the premature baby might be benefited by the administration of estrin. The argument in favor of giving the estrogenic hormone is based in part on several observations:

1. The blood of newly born babies contains a comparatively large amount of estrogens.

2. The hormone is rapidly excreted by the kidney, and the urine is estrogen-free after about four days.

3. A baby born prematurely is at a disadvantage because it lacks the stimulus of the estrogens which would normally have been present in its blood had it remained in utero.

4. The administration of estrin helps to make up this deficiency, especially since the fetus derives the largest share not only of its minerals but of the sex hormones during the last six weeks of pregnancy. (The editor's attention has been called to the interesting observation of Dr. H. A. Parmalee that premature babies do not develop engorged breasts as do most full time babies on estrogen.)

Whether the arguments thus advanced are valid or not is of little moment. The fact remains that estrogens have been given to premature infants with encouraging results. Several investigators are inclined to believe that female infants are apt to be benefited more than males, while others report equally good results for both sexes.

A summary of the beneficial results which have been reported following the administration of estrogens to premature infants is as follows: the initial weight loss is less; the food is taken more readily; the gain in weight is better; and, finally, there is a definite decrease in the mortality of the infants thus treated.

The treatment as outlined by various investigators is as follows: 500 units of amniotin are given hypodermically daily for not more than seven days; or, better, the preparation may be given orally provided the infant retains it. For the latter mode of administration, the dose is 500 international units, which is best mixed with a dram of warm water and given twice daily.

The treatment is reserved for premature infants who fail to assimilate milk and who are not gaining in weight. The estrogen does not appear to cause any undesirable results, but it must be borne in mind that these estrogenic hormones are potent agents and that it is imperative that the treatment be not extended beyond the five or seven day period. A. J. Q.

Cancer in Wisconsin

By WILLIAM C. KEETTEL, M. D.*
Madison

DURING the last thirty years there has been a marked increase in the number of cancer deaths. In 1910, 1,539 persons died from this cause, the rate being 65.9 per 100,000; by 1941 there were 4,215 cancer deaths, with a rate of 134.3. The question has never been definitely settled whether this represents an actual increase in the incidence of malignancy or merely a relative change.

At the present time, the weight of evidence points toward a relative change, with the following factors playing an important role: 1. The average length of life has increased from forty years in 1910 to over sixty years in 1941. A greater number of persons are now living to an age where cancer and other constitutional diseases play an important role as the cause of death. 2. Such common diagnostic procedures as tissue biopsy, bronchoscopic and cystoscopic studies, and the use of contrast media in roentgen-ray studies all have been popularized during this period. These procedures and others have increased the efficiency and effectiveness of our diagnostic procedures so that more cases are now diagnosed. 3. There has also been a great improvement in the reporting of deaths during this time.

Despite the fact that there may not have been a marked increase in the actual incidence of malignancy, we still have the unsolved problem of more than 4,000 persons dying annually of this cause.

Since cancer is the second cause of death, every effort must be directed toward preventing deaths from this cause. The Women's Field Army of Wisconsin has performed a distinct service in this state by its lay educational programs; it has constantly emphaized *that cancer is curable when found early and promptly treated.* It is indeed fitting that April was designated as "Fight Cancer Month" by Governor's proclamation, again calling our attention to such a vital health problem.

The State Medical Society of Wisconsin, through its Committee on Cancer, has been extremely active in many phases of cancer control. This committee felt that statistical analyses were essential to the further progress in the control, diagnosis, and treatment of cancer. While the death certificates give valuable information concerning cancer deaths, certain additional information is necessary for analysis, such as the actual number of cancer cases treated each year, the type of malignancy, the predisposing factors, the method of treatment, and the promptness in seeking medical attention. To obtain this additional morbidity data, a law which made cancer reportable was passed in 1933 under the sponsorship of the State Medical Society of Wisconsin. The law appears in section 140.05 under "Powers and Duties of the Health Officer" and is worded as follows: "Any physician knowing or having reason to know that a patient treated or visited by him has cancer, carcinoma, sarcoma, or other malignant growths shall report the same to the State Board of Health, in writing, on blanks furnished by said board and as it directs. These reports shall be confidential and not open to public inspection." To obtain uniform reporting of such information, a standard card was devised and distributed to all Wisconsin physicians.

In 1934, 1,020 cards were received. Between 1935 and 1939 the number varied from 1,285 to 1,345. Since 1940 there has been a decided decrease in the number of reports received, in 1942 only 743 cards were sent in. It is estimated that 3 living cancer cases should be reported for each cancer death; hence, in 1942 approximately 12,645, instead of 743, cases should have been reported to the Board of Health.

* Obstetric consultant of the State of Wisconsin Board of Health, Madison.

In checking over the 1942 cards, certain facts seem worth mentioning: 1. Only 6.7 per cent of the cards were sent in by individual physicians (excluding teaching hospitals and certain clinics). 2. 87.3 per cent of the cards were sent in by five institutions in the state. 3. Only 21.6 per cent of the cards were completely filled out.

We have failed in achieving the original purpose of cancer reporting. As physicians, we have a double responsibility towards this law: first, with adequate cancer reporting, we will have valuable information to gauge the weakness and effectiveness of our present cancer control activities; and, second, this law was initiated and sponsored from its beginning to its enactment entirely by our profession.

During 1943 the regular cancer educational program will be conducted as usual. In addition, a real effort will be made to improve cancer reporting in Wisconsin. We can still achieve the original purpose of the law if each physician will do the following: 1. Report each cancer case. If patients are referred elsewhere for therapy, do not depend upon the consulting physician to report the case; send in the card yourself. Duplication can always be eliminated. 2. In the larger urban areas, see if arrangements cannot be made through the hospital record room to report each hospital case of malignancy. 3. See that each card is completely and properly filled out. 4. See that actual use is made of the accumulated information in scientific articles.

Thomas J. O'Leary, M. D.

WE, TO whom the beginning and the ending of life have lost the character of unusualness and have taken on more the status of the commonplace, are still made to give pause when Death summons a colleague. Inevitable as we know it is, proximate as our judgment dictates it to be, it is always unexpected, unseasonable, perhaps even illogical.

So it was with the passing of Dr. Thomas J. O'Leary. His long experience as a surgeon had made of him an invaluable counsellor and a wise consultant; his devotion to his profession had made him one of its broad, tolerant, and vigorous protagonists; and his services to countless hundreds in his community had made him one of its well loved citizens.

In his death, the practice of medicine has lost not only one whose personal services reflected credit upon the profession but one whose opinions and judgments, mellowed by a vast experience, reflected sane and orderly thinking. There are perhaps few personalities whose actions are characterized by quick decision and sharply crystallized expression who do not engender some enmities; I believe Tom O'Leary was an exception. Vigorous and uncompromising as his decisions were, his fellow practitioners felt instinctively that they were dictated by rugged honesty. His surgical skill is too well recognized to require embellishment; if it was exceeded by any one thing in his years of practice, it was his professional integrity.

Those of us who called him friend will not soon find someone to take his place. What we say of him will add little to the stature he has himself attained. As a sixteenth century writer has so well said: "Death comes to all, but great achievements raise a monument which shall endure until the sun grows cold."—JAMES W. MCGILL, M. D.

During the four years 1937–1940 tuberculosis caused more deaths in the United States than were caused by all the battles of all the wars in which this country has been engaged, beginning with the Revolutionary War and continuing through the first World War. Plunkett, Robert, M. D.: N. Y. State Dept. of Health Bull. (Feb.) 1943.

The Nation at War

In this section of *The Journal*, to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Statement of the Surgeon General of the United States Army

The Army is increasing in size; more medical officers are required. New units are being formed, and many new general hospitals are under construction at many points in the United States. Some basic training must be given to medical officers before they are assigned to purely medico-military duties; for this reason, they are needed one or two months prior to actual assignment. For the protection of the health of the civilian population, the quotas for physicians must be fairly distributed throughout the country. Certain states are far behind; they will, it is hoped, do everything possible to furnish their quotas at once.

Statement of the Surgeon General of the United States Navy

In order to plan intelligently, I have reviewed the personnel situation in the Medical Department of the Navy. There is a deficit of approximately 900 medical officers for the next six months, based on minimal requirements. The Bureau of Medicine and Surgery calls medical officers to active duty when billets are available, does not build up too large a reserve at any time. Consequently, procurement must go on in an orderly fashion if we are to meet the demands that will be placed upon us as the offensive fighting develops. We can not afford to have the deficit increase beyond its present level; if it does we will not be able to give first-class medical service to our wounded.

The Medical Department of the Navy is charged with maintaining the health of all the personnel of the Navy and the Marine Corps; in addition, it must care for the dependents of the officers and men. We look to the medical profession of our nation to come forward with the available doctors that can be spared from civil life to aid in our military necessity. In the main, the profession has responded nobly. There are some localities where this is not so. In those localities the medical profession should cause the pressure of public opinion to bear on all eligible doctors and thereby bring to their attention the seriousness of failing to do their patriotic duty.

The medical profession is faced with a challenge of furnishing medical service to the armed forces and to the civil population during the active state of war and in the postwar period, which we hope is not too far distant. Should the profession fail in either regard, many forces may develop that will destroy the practice of medicine as we know it. This would be disastrous, and it is something that we can not afford to allow to come about. In all seriousness, the doctors of medicine in the United States should take stock carefully of their own immediate situations and should give every assistance in planning to see that medicine plays its responsible part in this and coming years.

Statement of the Surgeon General of the United States Public Health Service

During the next twelve months, the Public Health Service will require approximately 600 medical officers for full-time active duty in the reserve commissioned corps. These physicians will be recruited on an average of fifty a month—twenty-five for service in the United States Coast Guard, and twenty-five for general service.

In addition to the medical officers assigned to the Coast Guard, physicians are needed for duty in the Marine Hospitals and the medical program of the War Shipping Administration, as well as for detail to general public health work in state and local health departments, and for such specialized war programs of the Public Health Service as tuberculosis control, venereal disease control, industrial hygiene, and community medical services.

The Service also expects this year to commission some 5,000 physicians in the inactive reserve. These doctors will be available for active duty in the event of acute emergency in their own or nearby communities. They will not be called for active duty unless an acute emergency exists and will be retained only for the duration of such an emergency. This recruitment of inactive officers is undertaken as a part of the cooperative program of the Public Health Service and the Office of Civilian Defense.

The needs of state and local health departments for physicians have increased greatly during the past year. In January, 1942, it was estimated that state and local health departments would need 600 physicians. As of January, 1943, the exact needs have not been determined, but the Public Health Service has, at the present time, requests from the states for 185 medical officers to be assigned to duty in war areas alone.

According to reports from state Procurement and Assignment chairmen, as of March 23, 1943, 286 additional doctors for civilian practice are needed in 176 counties located in thirty-eight states. An-

other twenty-two counties in the same states report a shortage of physicians but do not specify the numbers needed. In the remaining ten states, no needs were reported.

These 198 counties reporting immediate needs represent only 7 per cent of the 2,654 counties in the thirty-eight states and only 6 per cent of all counties in the country. Nevertheless, it is apparent that civilian communities are feeling increasingly the pinch of the physician shortage, since experience has shown that local needs become acute before they are expressed in formal reports. In the joint studies made in forty-two areas by the Public Health Service and the Procurement and Assignment Service, it has been determined that fifty-nine physicians and five dentists are needed in these areas—an average of 1.5 per study. The Public Health Service has been requested to supply thirteen of these physicians and dentists, or 23 per cent of the determined need.

On the basis of these forty-two studies, it is estimated that 500 physicians and dentists will be needed in 332 areas to be surveyed in the next coming fourteen months, or by June 1, 1944. It is anticipated that 80 per cent of these, or 400, will be supplied by voluntary relocation through the regular channels of Procurement and Assignment, and that the Public Health Service will be requested to assist in meeting the needs for the remaining 20 per cent, or 100 physicians and dentists. This may be done either through financial assistance to physicians desiring to relocate in areas requiring their services or through assignment of Public Health Service personnel upon request of the proper authorities.

Although it is impossible to project with accuracy the 1943 needs of civilian communities, we must face the fact that the shortage undoubtedly will increase during and after the filling of the 1943 military quotas and that the chances of meeting civilian needs, as well as replacing physicians who die or withdraw from practice because of disability, will correspondingly decrease. Furthermore, we cannot predict at this time the possible needs of certain rural areas, which now may be adequately supplied but which will require additional public health and medical services during 1943, should the Government move a large number of farm families into these areas for the food production drive. It is believed that joint action of the Public Health Service and the Procurement and Assignment Service will serve to meet urgent needs in civilian communities.

Statement of Chairman, Directing Board Procurement and Assignment Service For Physicians, Dentists and Veterinarians

Figures are now complete on the 1942 quotas for supplying physicians from the various states. Forty states have exceeded the 100 per cent figure of their quotas. Five states were above 90 per cent of their quotas. Four states—New York, Connecticut, Massachusetts, and Nevada—were below 90 per cent of their quotas.

Nevada is the lowest state but has a total quota of but thirty-five doctors. It has provided twenty-three and deserves special consideration because its population is thinly scattered over wide areas.

This statement would not imply any reflection on the patriotism of those members of the medical profession who have been marked available by the Procurement and Assignment Service in these three states and who have not sought a commission. I would only present the facts and let each one draw from these facts whatever deductions he individually chooses.

Certain unavoidable considerations must be faced in these figures. Four states failed to provide 90 per cent of their 1942 quotas of doctors for the services. Three of these states, New York, Connecticut, and Massachusetts, are eastern seaboard states and among the most populous ones in the Union. These populous states have large cities in them which now have more doctors per 1,000 persons than most other parts of the country. Largely because those doctors marked available by the Procurement and Assignment Service have not sought commissions, these states are below their quotas.

Unless more of the doctors in these cities found available for military service by the Procurement and Assignment Service apply for commissions in the armed forces with reasonable promptness, still more doctors must come from rural communities. This will greatly complicate the problem for those communities in their own and other states since many rural communities are already none too well supplied with doctors. Such inequalities in medical service as now exist are in a considerable measure the result of the conditions herein stated and cause occasional problems of rural medical care which become practically insurmountable for the Procurement and Assignment Service with its present limited authority. With all these facts in mind, with the responsibility of medicine to the country and to itself such as it is, the quota figures particularly in New York, Connecticut, and Massachusetts should be brought up to par by an intensive effort of the state medical societies through their executive bodies, preferably by an organized state medical society campaign.

The provision of doctors for the armed forces is not only the special obligation of medicine but a responsibility which it acknowledges and accepts as its part in the war effort. Each state that has not met its 1942 quota will be kept informed of its position in relation to its quota and its position in relation to other states. Otherwise, a state is denied the pardonable pride of satisfaction in meeting its quota or pampered against facing a distasteful position in relation to other states.

Provision Being Made For Civilian Health

WPB Survey Reveals Hospitals Well Equipped

Despite increasing military and lend-lease demands for hospital equipment and medical supplies, adequate provision is being made to maintain the health of civilians, the War Production Board declared this week. In 1942, the 6,345 registered hospitals in the United States expanded their facilities by the addition of almost 60,000 beds—of which approximately 20,000 are for civilians, the rest for the armed forces and veterans—and almost 5,300 bassinets.

Since January 1, 1942, construction of 260 new hospitals, or extensive additions to existing hospitals, have been approved by WPB. Some of this construction was completed in 1942 and, together with construction begun in 1941 but not completed until 1942, represents last year's expansion in facilities. However, most of these hospitals and additions will not be completed until this year and will increase by many thousands more the number of beds available for patients.

Grant Hospital Priorities

At no time in the country's history have so many hospitals been functioning as at present. And WPB is continuing a consistent policy of granting priority assistance for any hospital needed as a result of war conditions or vitally essential to the health of a community. Hospital specialists within WPB's Government Division are charged with the responsibility of making sure that hospitals obtain the equipment and added hospital-bed facilities without which they cannot operate or for which there is a genuine need—with the least possible use of critical materials.

While hospital facilities have increased, demand for them has also increased. Existing equipment will have to be kept in repair and used to the fullest extent possible. Facilities for such repair and maintenance are available; essential equipment can be replaced when necessary.

New hospital beds, mattresses, and springs—and enough of them—are being manufactured from the same materials and, according to the same specifications, as before the war. Iron and steel may still be used for operating-room equipment. Even work tables, chairs, and stools for operating rooms may be made of these critical materials.

Six Hundred Doctors Relocated

Reports received by the War Manpower Commission's Procurement and Assignment Service for Physicians, Dentists, and Veterinarians show that approximately 600 physicians have changed their places of residence and practice in the last few months, Chairman McNutt announced last week. The Procurement and Assignment Service, a division of the Bureau of Placement, it was explained, makes an effort to accomplish such relocations when the medical needs of the civilian population would be better served.

Military Notes

Lieutenant John E. Martineau writes from somewhere in the South Pacific as follows: "Out here news of our colleagues at home is most welcome and even more so are the items about our friends and classmates who are in the Army or Navy.

"Your letter mentioned **Dr. (Lieutenant) A. L. Reinardy** of Union Grove. I spent five months in the 115th Medical Battalion with him in the Hawaiian Islands. Also in that group were two other Wisconsin boys—Dr. Walter Richer of Milwaukee, a graduate of Marquette in 1939, and Dr. Harold Youngreen of Monticello, a graduate of U. W. in 1941. Dr. Reinardy and I came on active duty in July last year. He is still a member of the medical battalion in the Islands. I left that organization in February to join the 26th Station Hospital on one of our South Pacific islands. From a professional viewpoint this was quite a break for me as I have much more opportunity to do medical and surgical work. A few weeks ago I had the pleasure of meeting one of my old surgical professors—**Dr. (Major) Forrester Raine** of Milwaukee. He was on a tour of surgical inspection at the time."

Lieutenant Martineau's home is Elkhart Lake.

—△—

A letter from **Lieutenant L. J. Keenan** indicates that he entered the service of the United States Navy January 18, 1943, and that he is now located at Cincinnati, Ohio. Lieutenant Keenan practiced at Fond du Lac before his induction.

—△—

Lieutenant Colonel B. J. Birk, formerly of Milwaukee, was recently advanced from major to lieutenant colonel at Fort Sheridan, where he is assigned to the Post Hospital as Chief of Medical Service.

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Since January, the California Desert has been the location of **Captain Milton D. Davis**, formerly of Milton. Captain Davis entered the service October 30, 1942, at Camp Hood, Texas, and was immediately assigned to the 706th Tank Destroyer Battalion.

—△—

Lieutenant Commander A. M. Hutter, formerly of Fond du Lac, is stationed at the United States Naval Hospital, National Naval Medical Center, Bethesda, Maryland.

—△—

Inducted into the Army on April 14 with temporary duty at Carlisle Barracks, Pennsylvania, **Lieutenant William A. Hilger**, formerly of Milwaukee, has since been transferred to Lowry Field, Colorado, for temporary duty pending further orders.

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The first station of **Lieutenant Gordon E. Carroll**, formerly of Laona, is the United States Naval Hospital, Norman, Oklahoma. His assignment began May 3.

Lieutenant Commander Chalmer Davee, formerly of River Falls, is at present on duty at Great Lakes, Illinois, on dispensary service.

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Lieutenant Commander W. A. Ryan is reported to have enjoyed a ten day leave at his home in Milwaukee. Inducted into the service of the United States Navy on March 4, 1942, Lieutenant Commander Ryan is at present assigned to the Naval Training Station at San Diego, California.

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A communication from Mrs. A. J. Harris states that her husband, **Lieutenant A. J. Harris**, left early in January for service overseas. Lieutenant Harris left Adams to enter the service in November, 1942.

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Writing from the Station Hospital at Kearns Field, Utah, **Lieutenant W. J. Schutz**, formerly of Shawano, informs us of his change of station from Randolph Field, Texas. Concerning the news letters, he comments: "Carry on; I know all the Wisconsin physicians in the service appreciate your letters."

—△—

Lieutenant Joseph F. Kelley, a physician and surgeon from Janesville, is serving as aviation medical examiner at the Army Air Force bombardment base at Will Rogers Field, Oklahoma. He reported for service on April 22. Mrs. Kelley and the five children will remain in Janesville while Lieutenant Kelley is in the service.

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Captain Robert W. Shaw interestingly describes his training and experiences in the Army in a letter to the Secretary's office: "I am one of the many members of the Wisconsin Medical Society whom you assumed when you took over the work of George. We have never met, and it may be some time before we do. I am also one of the many Wisconsin physicians who happen at the time to be in the Army of the United States. I had been practicing in Marinette. I left there last October 20 and reported at Camp Joseph T. Robinson, Arkansas. During the time I was there, which was about six weeks, I was taught soldiering. At that time the medical side was so far away that I had begun to wonder what a medical officer was for. However, what we learned there was very much to our benefit. By learning to take orders, learning to drill, hike, pitch pup tents, roll packs, military courtesy, and all the paper work we had already heard about, we were able to handle men as we had been handled. Many of the doctors were very discouraged during this period of training. However, many, in fact most of them, could reason just why we had to go through such a training. We may have been good doctors, but we still had to be taught to be Army officers. And six weeks is really a very short time to teach that to a bunch of men who never had been closer to the Army than to see a military parade, at a distance, once or twice during a lifetime.

"After this preliminary training, we were sent out to more or less permanent posts, where we found that we had just learned enough to know that we did not know anything about the army way of doing things. I was sent, along with another doctor who was with me at the 'Training Pool,' to a Quarter Master Battalion at Camp Shelby, Mississippi. Here he and I became the medical officers of the Medical Detachment of the 304th Quarter Master Sterilization Battalion. Besides taking care of 'sick call' each morning, we had to immunize each man against small pox, typhoid, and tetanus. This really kept us quite busy, for, although the detachment was supposed to have ten trained enlisted men, they were not here, and the Lieutenant and I really had a workout. We were getting the medical side of it with a vengeance, now. Besides being medical officers, we also had to be sanitary officers for the battalion, that is, inspect mess halls and latrines every day, as well as the entire unit area. As if that did not take up all day, we had first-aid lectures to the Non-Coms of the unit, to the soldiers, camp and bivouac sanitation. There were a lot of things which we do that in civil life the health officer of the community did. We did and still do it all. Of course, in a place like this, we all miss our hospital work, and we all live in hope that some day we will get orders to go to some army hospital for duty. But until that time comes, we do what our job calls for and do it to the best that is in us. At times one of us gets a break from the routine and travels with a troop train to some other post and then returns to his original duties.

"Finally, after a month of working by ourselves, we were told that we were getting our enlisted men for the detachment. But when they came, it was found that they also came directly from a reception center, and, therefore, the training of these men was added to our other duties. It took six to eight weeks, so that this group of men developed enough to be of very much help in the dispensary or the field. Now, however, they are quite helpful in all of our work.

"The commanding officer of the battalion has been trying to make a line officer out of me. I have been taking the battalion on bivouacs and have been inspecting all of the rifles which have been issued to the unit. All this is entirely out of the line of a medical officer, but if one is to be in the Army, all that he can learn about the other branches of the service may come in very handy some time, and you may be glad that you know it. Although a medical officer never commands troops, with the exception of his own medical enlisted men, the time may come when he finds that he may have to in some emergency.

"The troops which I am connected with is what is known as a sterilization and bath outfit. In other words, we delouse and bathe units which have become infested with the 'louse.' All of the clothes and bedding are 'deloused' in a large steam pressure

chamber and the men are given shower baths and inspected for the louse and then given clean clothing throughout. The battalion has sixteen such units, and they can sterilize and delouse a good many soldiers in a day's time. But the Army is big, and although the louse does not at present seem to be very plentiful, here in the United States at least, the time will come when we will probably be working night and day. This will probably be more after the war in the occupied countries where cleanliness has been impossible for several years. I probably will not be attached to this outfit at that time, because the battalion will be split into sixteen units spread over a very large area, and it would be impossible for one small medical detachment to service them all.

"This gives you, in a small way, an idea of just what one of the Wisconsin doctors is doing in the Army. It is necessary work even if it is not entirely to my liking. There is one thing that worries me, and I don't doubt that it is worrying those other doctors who are in the Army. What about after the war? We all will need some kind of postgraduate work to let us catch up with those that stay at home and are able to carry on a generalized practice. Also, we will have to start in just as we did when we left medical school to start building up a practice again. To tell you the truth, it kind of scares me to think of having to start in again at my age with a family and other responsibilities. However, that is part of the war, no doubt."

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Lieutenant Gordon W. Petersen is completing a six weeks course in maxillofacial plastic surgery at Harvard. Most of his period of service in the Army has been spent in evacuation hospitals.

Mrs. Petersen is remaining at Neenah, where Lieutenant Petersen practiced before he entered the Army.

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Lieutenant Commander L. J. Schneeburger recently assumed the position of Chief Medical Officer at the Naval Barracks, Portland, Oregon. At the end of the fourth day of a ten day leave at his home in Milwaukee, he was called back for his new assignment.

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By V-Mail comes word from **Lieutenant David Twohig**, formerly of Fond du Lac, that he is now overseas serving as Assistant Evacuation Officer for the European Theater of Operations with headquarters in England. Lieutenant Twohig received his preliminary training at Carlisle Barracks.

He says, in part: "It's very interesting to hear the news from the home state and of the recent happenings in the practice of medicine in Wisconsin. It certainly is good to read of the other medical officers whom all of us knew but have had no word of. I might say that any and all news from home is most welcome when one is so far from home. We don't get too much." He sends his best regards to the profession at home.

The April 24, 1943, issue of *The Journal of the American Medical Association* lists the following Wisconsin members of a recently graduated class in aviation medicine for aviation medical examiners:

James S. Feurig, 1st Lieutenant, Seymour

Adrian William Frankow, 1st Lieutenant, West Bend

Urquhart Louis Meeter, Captain, Medford

Harry Lloyd Schwartz, 1st Lieutenant, Kenosha

Graduation exercises were held at each of the three Army Air Forces classification centers, where the practical portion of the course had been conducted. The didactic portion of the course was conducted at the School of Aviation Medicine in Texas.

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Captain Albert J. Boner, formerly a Madison physician and now a member of the United States Army Medical Corps and stationed at the reception center at Ft. Leavenworth, Kansas, spent a five-day leave in Madison during the early part of May. He was accompanied by Mrs. Boner and their son, David. Captain Boner entered the medical service of the Army in December, 1942.

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The silver star medal is the award of valor recently presented to **Commander Everett B. Keck**, now a medical officer serving with the Marines and formerly a resident surgeon practicing at Madison. The award was presented to him in recognition of his able use of captured Japanese surgical instruments on Guadalcanal after his own had been lost as the result of the sinking of a United States ship. The Japanese instruments, which his corpsmen found in a captured village near Henderson Field, served him during his entire stay on the island.

According to the official citation by Admiral W. F. Halsey, "Commander Keck, by his great coolness, personal gallantry and intrepidity during enemy bombing and shelling raids, maintained a high degree of morale and efficiency in his command.

"He personally performed a large number of surgical operations for the care and relief of those wounded in battle. In the conduct of his professional work he exhibited a very high degree of surgical judgment and ability."

Commander Keck highly praised the navy doctors, corpsmen and marines who attended all casualties in the area as follows: "The officers and men under my command performed with the utmost efficiency and disregard for their personal welfare. I cannot praise them too highly. Their devotion to their work was splendid.

"Our area was hit seventeen times during one large scale bombing attack, and on three occasions Jap submarines and destroyers shelled our area, causing minor damage. It gets rather trying working under those conditions."

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« « « EDITORIALS » » »

"The Right of Voluntary Action"

IN TIME of war, certain phrases tend to become hackneyed and trite. It is difficult sometimes to know just how to revitalize the valid suggestions with which we are concerned and to bring them closer and deeper into the consciousness of the people as a whole.

We hear much of "total war" and the "all-out war effort." We hear much of the "privilege" that exists for the physician to serve his country in time of war. We hear much in the character of praise for the tremendous contributions already made by the medical profession. The terms "available," "not available until replaced," and "essential" have become rather commonplace in our vocabularies. "The Procurement and Assignment Service" is used as glibly to describe the agency which exists at the suggestion of the medical profession as are medical terms descriptive of patient welfare.

During the course of such a period it becomes necessary to review the procedure from the beginning. It becomes necessary to redevelop the problems or, perhaps to use a better description, to reassess the entire situation.

It is clearly recognized now that certain groups of our citizenry, as groups, are most important in the war effort. Certainly this can be said without any exception so far as the medical profession is concerned. This is witnessed by the fact that upwards of 45,000 physicians are now said to be serving with our soldiers and sailors, and this by a program of voluntary enrolment. Remarking on this fact, an editorial writer in the *Connecticut State Medical Journal* said: "Their right to make such voluntary action in a time of war is unique for no other group in the nation has been given this privilege. This great number of our physicians now serving as medical officers is a fine tribute to the ideal of service that characterizes our American doctors but still the demand for physicians to care for our armed forces is not yet satisfied. That such demand is of urgent necessity must be plain to anyone who realizes the size of these forces which will be required."

That the whole objective of the procurement of physicians for the armed forces has not yet been met is neither a reflection upon the Procurement and Assignment Service nor is it a fault of that agency, which exists to serve the right of voluntary action by the physicians. In Wisconsin, as elsewhere, it is the duty of this organization to reconcile the needs of the armed forces, as assigned to Wisconsin, with the needs of the civilian population for adequate medical service.

Determination of availability or nonavailability is not arrived at in any haphazard or inadvertent fashion. The situation in every community of the state has been carefully reviewed, and a complete physician inventory maintained on a current basis, which has been supplied to the Procurement and Assignment Service. And the relationship of medical service as it existed in periods prior to the war, and as it now exists, is a subject of current study in communities throughout the state. It is apparent that Wisconsin cannot supply its procurement objective without there being some impact upon the convenience of communities. But it is something in the character of a tribute to careful study that Wisconsin is not a state in which the situation is described as critical insofar as community needs are concerned. Thus, to the physician under 45 years of age who has been declared available there is much for sober thought. As the editorial writer in the *Connecticut State Medical Journal* aptly stated, "He must be mindful that hundreds of thousands of citizens will enter the armed services as enlisted men during the next few months and that there will be little consideration for dependency. This means that his status as an independent citizen will change. If he wishes to maintain the privilege still accorded him as a physician this can be insured with certainty only by applying for a commission without delay. If this is not done there is no doubt that like the rest of his fellow citizens he will become subject to the disposition of the Selective Service. When this occurs the matter passes completely out of the hands of the Committee which has been endeavoring to cooperate with him in securing an officer's commission. He is now under the jurisdiction of the Selective Service. Under a recent ruling he will be subject not only to the usual induction procedure but will be required to take the basic four months training before he may be considered for a commission as a medical officer. In one nearby state this actually has happened to some physicians who did not apply for commissions in time to avoid the dilemma.

"Finally, the physician who has been declared available for service should realize that the voluntary program which is still open to him has been successful solely because other physicians have voluntarily entered service in sufficient numbers to meet the needs of the armed forces. He should be reminded also that each of us possesses the right of voluntary action only so long as Our Nation can depend upon such action for support in a national crisis."

". . . help keep him cheerful . . ."

MEMBERS are giving hours of their time and immeasurably of their energies in participating in the needs of the country during this period of great war activity. Such activities include public health procedures, Procurement and Assignment, civilian defense, Red Cross and first aid, Red Cross and blood banks, Selective Service, ad infinitum.

But there is one more—keeping contact with those at the front lines. Wisconsin doctors are scattered on every front, and their need for the news of home is just as imperative as it would be for any of us were we with them. The V-mail is easy and inexpensive; write your brother practitioner—let him know how the home front is doing—help keep him cheerful—help keep him current on events at home. He is doing his part, and he must know that we are doing ours.

. . . . THE PRESIDENT'S PAGE . . . .

IT HAD never occurred to me that the time would come when I should be called upon to help finish the President's pages of "Frank" Butler, the man who loved medicine, medical men and the State Medical Society. I shall always remember him for his good judgment, for his loyalty, for his efforts to make things better, for his sacrifice of time in serving the cause of the sick. However, I know that he, as my friend, would agree with me that the Society numbers many in its membership with the same high ideals, the same desire to serve, and, in a high degree, a real record of service. It is the delight and satisfaction of the Secretary's office to receive countless letters from all over the state from members asking what they can do to serve. This is the spirit and this is the fact that has made the profession of medicine truly great. For a century the profession, under wise and honest leadership, has policed itself, has set up high ideals, has constantly improved itself but always with the public good foremost in mind. I think that we stand unique in this position.

We are in the midst of a great war, and the thinking processes of men are not normal; our whole political fabric has become so strange that thoughtful men are anxious these days. The faith and beliefs of our founding fathers as expressed in our Constitution, it would seem, has in many instances been set aside or forgotten. No one seems to know what the next day will bring forth. We are seeing new interpretations or applications of the law of the land. We depend upon the law to govern the conduct of men in an orderly process as is the process of nature orderly.

The war has touched practically every family in some way, some in a very painful way. We wonder about the postwar period. Will men this time be wise enough to establish in some way by law or agreement a peaceful world? In that period to come, what will be the fate of medicine, of business as we knew it, of the lives of men, of the national debt and a thousand other things? For my own part, I have great faith in the American people. The ship has listed heavily to one side, but it will right itself and come up on an even keel. Floyd W. Parsons has said: "We have learned a lot in recent times. Fortunately Europe has supplied object lessons that we will never forget. We have come to understand that the unprincipled demagogue can easily lead the masses to believe what they want to believe; that thrift, self denial, self discipline, and other age-old virtues are difficult to cultivate but easy to destroy; and that self-appointed dictators through the use of ridicule, lies, and threats can cause innocent people to turn their backs on proven fundamental principles and join the ranks of the supporters of the philosophy that established economic laws are now outmoded and have no further place or applications in this changing world."

We know what happened to France after her social experiments. Are we going to turn after this war to further experimentation along the lines of Socialism and the more abundant life? There is a madness in America today after money and power. Many will do anything to acquire it. Most of us believe in an orderly process of government and that those who work shall receive. I often have urged that the physician, an educated man, should not only minister to the sick but should advise, when called upon to do so, in other matters, government being one of them. Twenty years following the Napoleonic Wars, England found herself in about the same situation that we find ourselves today, a situation that will confront us after this war. She had been battling Napoleon in Europe, Africa and Asia. Like us, she had been financing her European Allies. In proportion to her population and income, her national debt was equivalent to the staggering load which we are piling on our own shoulders. Industry, trade and agriculture were burdened by an annual tax load estimated at half the national income. Her currency was depreciated, and her

budget badly unbalanced. Unemployment was widespread, and she had a larger proportion of her people on relief than ever before or since. But she recovered from it all, and according to some she did it by liberal, clear thinking and courageous, forward-looking and progressive action. They exposed the folly of bootstrap policies of government-lavish spending, restriction of trade and production, economic rigidities and pauperizing doles. They aroused the English people to opportunities which free and competitive enterprise can create for all. They showed the menace and reactionary aspects of unbalanced budgets, depreciated currency and expanded bureaucracy. They reversed the collectivist tendencies and set England on the course of economic freedom necessary for all economic progress. And so again, when the war is over, when those step in who would mold the ideas and ideals of the future life, may the physician participate (and he can without trepidation) and add his total experience to the postwar planning.

—R. G. Arveson, *Past-President.*

Legislature Moving Toward Sine Die Adjournment Annual Registration Bill Now a Law

Adjournment Forecast Sometime in June

WITH much of the major legislation disposed of in the current session, Capitol observers believe that the Sixty-Sixth Regular Session of the Wisconsin Legislature will adjourn about the middle of June. Although no resolution has been adopted at the time of this writing calling for sine die adjournment, it is apparent from various legislative developments that the move is contemplated in the early future. Recently numerous bills were withdrawn from legislative consideration by the members, and the trend is to dispose of all non-controversial bills as soon as possible, that the daily calendars may be finally cleared for adjournment.

Public health legislation has been of unusual interest during this current session.

THE ANNUAL REGISTRATION LAW

The annual registration law was sponsored and endorsed by the State Medical Society of Wisconsin because:

1. It provides the only means by which a current and correct inventory of physicians in Wisconsin can be maintained.

2. Such an inventory will be of immeasurable value in assisting in the proper distribution of physicians, particularly as this problem becomes acute at the conclusion of the war.

3. By annual publication of a list of physicians, every law enforcement officer in the State of Wisconsin will know who is licensed to practice, and is practicing, in this state.

4. For the first time it will provide the State Board of Medical Examiners with a sum sufficient to enforce the Medical Practice Act and thus secure the elimination of the unlicensed quack and charlatan.

5. It has proven a highly satisfactory public health law in twenty-three states in which it is now operative.

Governor Walter S. Goodland signing the annual registration bill on May 17, 1943. Witnessing are, left to right, Dr. R. M. Kurten, Racine; Dr. R. G. Arveson, Frederic; Dr. Gunnar Gundersen, La Crosse; Mr. C. H. Crownhart, Madison, and Dr. C. A. Dawson, River Falls.

The bill calling for annual registration of physicians was signed by Governor Goodland on May 17, in the presence of representatives of the State Medical Society, and has since been published and is now known as Chapter 155, Laws of 1943. The measure was developed after long study by a special committee appointed at the request of the House of Delegates in its 1941 session. The committee, composed of Doctors R. G. Arveson, Frederic, chairman; Eben J. Carey, Milwaukee; William S. Middleton, Madison; C. A. Dawson, River Falls, and C. D. Neidhold, Appleton, secured copies of similar laws in effect in twenty-three other states and made a comprehensive study of them as well as viewing their acceptability from the standpoint of public health achievements.

Funds Have Never Been Sufficient

As a result of this study, the committee reported to the House of Delegates in 1942 a succinct statement of its composite opinion. The committee pointed out that the Medical Practice Act involves "a field not alone exacting, but comprehensive. Fundamentally, it involves a public health law of Wisconsin, created under the police powers of the state, as one in which the health interest of the sick and well alike is to be properly protected. This notable fact is present in the Wisconsin law as well as in many others—a state agency is charged with its enforcement with the practical effect that local agencies otherwise responsible have left the administration of the law largely to state authorities. Regardless of the responsible agencies at the state level, the funds provided for the purpose of enforcement have never been sufficient for the agency to consider more than lip service to their responsibilities."

After suggesting that it was not necessary to enter into a detailed discussion of the en-

orcement problem, the committee emphazed that the Medical Practice Act is deerving of enforcement from the fact that is a law of the state and remarked that every duly licensed physician in the State f Wisconsin knows of daily violations hich are unrecognized by the public, casully ignored by apathetic local officials, and o numerous to permit of effective action by ate agencies.

"A house built upon sand offers neither afety nor permanence to its inhabitants; a ood law, the administration of which is inufficiently financed, offers false security to ose seeking or expecting the haven of its rotection. So is it, in your committee's udgment, with reference to the Medical 'ractice Act in Wisconsin."

The Medical Practice Act is Sound

After discussing the procedure for apointment of members of the administrative oard and other problems, the committee's eport to the House of Delegates emphasized hat the law in Wisconsin was sound, in the nterest of the public health, and that its ailure in many of its purposes is "no reflecion on those charged with its administraion, but leads those who have studied the roblem inevitably to the conclusion that ack of financial support is the main cause of his fault. It may be argued that the Society hould urge larger legislative appropriaions to cure this situation. The record will how that such has been the position of the Society time and time again.

"However, the delegates should recognize hat the Medical Practice Act, like many nother police law, is not one which dramaically demonstrates its own public value. There are many laws on the statute books of he state, and in the complexities of governnent today it is small wonder that some of hem are more than momentarily lost from iew in the legislative halls."

Concluding its report, the committee noted that the medical profession in Wisconsin, as elsewhere, had not shirked a responsibility that is clearly its own in the final analysis and, consequently, recommended that the Society sponsor a measure requiring the annual reregistration of physicians and designed to provide the State Board of Medical Examiners, or any other agency subsequently charged with enforcement of the Medical Practice Act, with sufficient wherewithal to perform its duty.

Following consideration of the committee's report by the House of Delegates, the records of the 1942 Annual Meeting show adoption of the report and consequent instruction to the Committee on Public Policy to prepare and support such a bill at the forthcoming 1943 legislative session.

The Law an Aid to Procurement and Assignment

At this time it became apparent that still another reason existed for the introduction of this measure. The Procurement and Assignment Service had functioned actively and effectively during the year 1942, but as the first wave of those physicians from Wisconsin who entered the service of their country in World War II began to subside, it became apparent that the Procurement and Assignment Service could not fully function in relation to the civilian health needs of the community without detailed and accurate surveys of physician personnel in each community in the state.

Acting upon its policy of cooperation with the Procurement and Assignment Service and at the request of the state office, the State Medical Society of Wisconsin immediately set into operation its full office facilities to develop this inventory,—an undertaking which was not alone tedious but most exacting and comprehensive beyond all anticipation. At once, it became apparent to the Committee on Public Policy and to the officers of the State Medical Society that such an inventory would be virtually 100 per cent accurate had an annual registration law then been in existence, and this further pointed out the need for such a law in order that the inventory could be maintained on a current basis and be of inestimable aid in providing for the relocation of Wisconsin physicians returning from active service with the armed forces.

All of this led to the introduction in the 1943 legislative session of bill 305, A., of-

fered by the Hon. David I. Hammergren, representing Buffalo–Pepin Counties. The provisions of the bill were simple and direct, and it is felt that under the able administration of the State Board of Medical Examiners and cooperating state agencies, the members of the medical profession in Wisconsin will have made a substantial contribution to the future of the public health of Wisconsin citizens.

Embracing the best features of similar laws existing in twenty-three other states, the annual registration law provides that every individual engaged in or entering upon the practice of medicine and surgery, osteopathy, or osteopathy and surgery in Wisconsin shall register with the State Board of Medical Examiners annually, at a fee not to exceed $3. The list of such registrants will be printed by the State Board of Health and distributed generally to public officials of the state, including local boards of health and law enforcement agencies.

". . . In No Way Affects the Law Relating to Licensure."

The measure confers no police or similar powers upon the State Board of Medical Examiners not already vested in it under the Medical Practice Act and in no way affects the law relating to licensure. Exempt from its provisions during the period they are in active service, physicians in the armed forces need not register until they return to civilian practice.

If the maximum fee of $3 is used henceforth, it is estimated that the State Board of Medical Examiners will ultimately receive approximately $9,000 to $10,000 a year revenue from this source,—an amount two and one-half times greater than the maximum appropriation for the enforcement of the Medical Practice Act made available in any recent session of the legislature.

Implemented by these funds, the State Board of Medical Examiners will be in an unusual position to cooperate with the State Medical Society and public health agencies in securing an adequate distribution of physicians within the State of Wisconsin and in apprizing applicants for licensure of locations in which public health needs may be served. In addition, public health officials and others will be able to ascertain with comparative ease the names of those who are duly registered to practice in Wisconsin in the fields of medicine and osteopathy. With the availability of additional funds, the State Board of Medical Examiners will be sufficiently implemented to secure the practical enforcement of the Medical Practice Act and the elimination of quacks and charlatans.

The success of the annual registration law in Minnesota and Iowa, as well as in the other states carefully studied, reassures Wisconsin physicians that in its enactment the State Medical Society, as its sponsor, the Senate, the Assembly, and Governor Goodland have taken a highly important step toward the future of public health protection in this state.

Other Measures

The State Medical Society sponsored two measures providing for an increase in the ceiling applicable to the salary paid the state health officer and deputy health officers. Both of these measures have successfully passed both houses and have been signed by the Governor, with the result that the ceiling on the salary of the state health officer has been increased from $5,000 to $6,000, and the ceiling for deputy health officers' salaries has been increased from $3,000 to $4,000 annually.

At this writing, two additional measures of importance have passed both houses of the legislature and now go to the Governor for ultimate disposal. These include a bill to permit the licensing of trained attendants in the physical care of the sick and the inclusion of the services of a physician within that section of the statutes which now provides for reimbursement to the hospital without prior authorization, where the facilities of the hospital are made available for the care of indigent sick, and where prior authorization therefor could not be secured without delay likely to be injurious to the welfare of the patient.

Bills introduced by Assemblyman Westfahl, of Milwaukee, legalizing and promoting unsupervised forms of medical and hos-

ital insurance schemes, and for a system of ompulsory health insurance in Wisconsin, ere decisively defeated in the Wisconsin ssembly.

A measure permitting chiropractors to se the title "doctor," now denied them by statute and Supreme Court decision, was withdrawn by its author, while two measures which would permit chiropractic services under the Workmen's Compensation Act still are pending but offer no promise of passage at this writing.

Council on Scientific Work Announces Program For One Hundred Second Annual Meeting to Be Held September 13, 14, 15

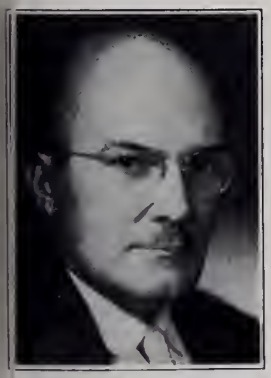
E. R. SCHMIDT
Chairman

A WARTIME program has been prepared for the One Hundred Second Annual Meeting of the State Medical Society of Wisconsin by the Council on Scientific Work. Individual members of the Council have been assigned specific phases of the meeting to develop and have reported their progress from time to time at meetings of the entire Council throughout the year.

Dr. E. R. Schmidt, chairman, asked that Dr. F. D. Murphy, Milwaukee, supervise the preparation of the scientific program and that Dr. C. D. Neidhold, Appleton, arrange and procure the scientific exhibits.

In view of the fact that the program is virtually completed, the following material is presented in order that Society members may have a preview of arrangements that have been made for the One Hundred Second Annual Meeting.

F. D. MURPHY
Scientific Program



C. D. NEIDHOLD
Scientific Exhibits

C. J. SMILES

H. K. TENNEY
Scientific Motion Pictures

The General Session

The topics, including several symposia, for the general session program have been selected and the speakers' acceptances received in most instances. Through the medium of symposia, it is possible to integrate the subject matter to be covered.

The symposium on the liver will embrace the following subjects:

- Physiology of the Liver
- Liver Function Tests
- Differential Diagnosis of Jaundice
- Preoperative and Postoperative Complications and Treatment
- Surgery of the Jaundiced Patient
- Summary and Discussion of the Foregoing Papers

Army and Navy experience has shown a high incidence of ulcers. That Wisconsin physicians might both review their earlier teachings in this field and also be informed on new discoveries and research work, the following symposium on peptic ulcer has been arranged:

- Etiology, Pathology, and Incidence of Peptic Ulcer
- Bleeding Peptic Ulcer
  - Medical Treatment
  - Surgical Treatment
- Ulcer Problem in the Armed Services
- Innocent and Malignant Lesions of the Stomach
- Operation of Choice in Peptic Ulcer
- Summary of Medical and Surgical Treatment

Section Programs

The chairmen in charge of the preparation of the several section programs are:

- Obstetrics and Gynecology—R. L. Cowles, M. D., Green Bay
- Surgery—D. H. Witte, M. D., Milwaukee
- Medicine (Cardiology)—A. G. Koehler, M. D., Oshkosh
- Ophthalmology and Otolaryngology—W. E. Grove, M. D., Milwaukee
- Pediatrics—H. A. Sincock, M. D., Superior
- Urology—W. M. Kearns, M. D., Milwaukee
- Orthopedics—R. E. Burns, M. D., Madison
- Radiology—L. W. Paul, M. D., Madison

Round-Table Luncheons and Breakfasts

Round-table luncheons have demonstrated their popularity through their continual growth. Requests were received after last year's Annual Meeting for a few round-table breakfasts in addition to the luncheons. Among the subjects which have been tentatively selected for the breakfasts (which wil be in addition to the usual fifty or sixty luncheons) are the following:

- Bedside Medicine and Newer Drugs
- Prevention and Treatment of Wound Infections
- Improvizations to Cope with Medical Emergencies in the Home
- Precautions in Telephone Prescribing
- Medication for Common Skin Diseases
- The Use and Abuse of Sulfa Drugs

Out-of-State Speakers

The out-of-state speakers who have indicated to Dr. Murphy that they will participate in the program are:

- Hart E. Van Riper, M. D., Children's Bureau U. S. Department of Labor, Washington D. C.
- Paul H. Holinger, M. D., Assistant Professo of Laryngology, University of Illinois College of Medicine, Chicago
- Edgar J. Huenekens, M. D., Clinical Professo of Pediatrics, University of Minnesota Medical School and University of Minnesot Graduate School, Minneapolis
- Donald C. Balfour, M. D., Professor of Surgery University of Minnesota Graduate School Minneapolis
- Cecil J. Watson, M. D., Professor of Interna Medicine, University of Minnesota Medica School and Professor of Medicine, Universit of Minnesota Graduate School, Minneapoli
- Frederick A. Coller, M. D., Professor of Surgery, University of Michigan Medical School Ann Arbor
- Sanford R. Gifford, M. D., Professor of Ophthalmology, Northwestern University Medical School, Chicago
- Dean Lierle, M. D., Professor of Otolaryngology, State University of Iowa College of Medicine, Iowa City
- Chauncey C. Maher, M. D., Associate Professo of Medicine, Northwestern University Medical School, Chicago
- Paul S. Rhoads, M. D., Assistant Professor o Medicine, Northwestern University Medica School, Chicago
- Frank C. Mann, M. D., Professor of Patholog and Experimental Physiology and Surgery University of Minnesota Graduate School Minneapolis
- Claude F. Dixon, M. D., Associate Professo of Surgery, University of Minnesota Graduate School, Minneapolis
- Rear Admiral Ross T. McIntire, Surgeon General, United States Navy, Washington, D. C
- George B. Eusterman, M. D., Professor o Medicine, University of Minnesota Graduat School, Minneapolis

Marion A. Blankenhorn, M. D., Gordon and Helen Hughes Taylor Professor of Medicine, University of Cincinnati College of Medicine, Cincinnati

Warren H. Cole, M. D., Professor of Surgery, University of Illinois College of Medicine, Chicago

John Romano, M. D., Professor of Psychiatry, University of Cincinnati College of Medicine, Cincinnati

John S. Coulter, M. D., Associate Professor of Physical Therapy, Northwestern University Medical School, Chicago

Dean Alphonse M. Schwitalla, M. D., St. Louis University School of Medicine, St. Louis

Captain W. E. Eaton, M. C., U. S. N., Great Lakes, Illinois

Scientific Exhibits

Because of the great interest shown in scientific exhibits at past Annual Meetings, the Council on Scientific work has laid even greater stress on the selection and correlation of the exhibits to be shown at the coming meeting. Many exhibitors have already given Dr. Neidhold assurance that they will participate. These are as follows:

Applied Anatomy
University of Wisconsin Medical School and Marquette University School of Medicine

Tropical Diseases
Marcos Fernan–Nunez, M. D., Milwaukee

Birth Certificates—The Importance of Accuracy
State Board of Health

Automobile Drivers Clinic
Motor Vehicle Department

Medical Literature Loan Packets
Medical Library Service

Chemistry of Vitamin K and Synthetic Hormones
American Medical Association

Chemistry of Gastric Antacids
American Medical Association

Tularemia—Spread and Control
American Medical Association

Tularemia—Pathology
American Medical Association

Botulism
American Medical Association

Hearing Aids
American Medical Association

Transmission of Diseases from Animal to Man
American Medical Association

Degenerative and Pathologic Changes in Lumbosacral Intervertebral Disks
R. H. Gormley, M. D., and M. B. Coventry, M. D., Mayo Clinic

Kraurosis Vulvae and Allied Affections
L. M. Randall, M. D., M. C. Piper, M. D., and L. A. Brunsting, M. D., Mayo Clinic

Use of Fascia Lata in Repair of Hernias
B. A. Mason, M. D., Mayo Clinic

Diagnosis of Addison's Disease
E. J. Kepler, M. D., H. W. Power, M. D., and F. J. Robinson, M. D., Mayo Clinic

Some Relationships of the Thyroid and Pituitary Glands to Iodine Metabolism
A. S. Chapman, M. D., and S. F. Haines, M. D., Mayo Clinic

Respiratory Protective Devices
H. H. Schrenk, M. D., United States Department of the Interior, Bureau of Mines

Scientific Motion Pictures

Scientific Motion Pictures were presented for the first time at the 1942 Annual Meeting. They proved to be so popular that it has been decided to repeat this feature at the 1943 meeting. Dr. H. Kent Tenney is again in charge of securing the films and is at the present time reviewing motion pictures from the British Information Services, the United States Army and Navy, and from other sources in order to procure films of superior merit.

Special Hospital Section

The Committee on Hospital Relations of the State Medical Society has asked the Council on Scientific Work and the Council of the Society to arrange a separate program for hospital superintendents, chiefs of staff, secretaries of staff, hospital administrators, and nurses. In this connection, the work of the Committee on Hospital Relations was initiated during the period that Dr. R. M. Kurten was chairman and has been carried to completion through the efforts of Dr. J. E. Habbe, present chairman. The subjects to be covered at this sectional meeting are:

Recent Legal Decisions of Importance to Physicians in Hospitals

Problems Concerning Graduate Education and Employment of Nurses, Interns, and Residents

Authorization Required for Professional Procedures

Wisconsin Hospital and Medical Payments Plan

Professional Accounting

The Relationship Between the Lay Hospital Board and the Hospital Staff

A Small Hospital Library

Interhospital Relations

A special luncheon will also be held and will be addressed by an outstanding figure in the field of medical relations in hospitals.

Technical Exhibits

The availability of exhibit space in the technical section was announced on March 13. Within forty-eight hours every available exhibit space had been reserved by pharmaceutical and supply houses. The firms who have reserved space for the meeting this year are as follows:

Mead Johnson Company
Schering Corporation
Coca-Cola Company
U. S. Hospital Supply
Kelly-Koett Manufacturing Co.
Physicians & Hospitals Supply
Belgard–Spero, Inc.
Pet Milk Company
C. V. Mosby Company
Petrogalar, Inc.
Lederle Laboratories
Smith, Kline & French
General Electric X-Ray Company
Wm. S. Merrell Company
H. J. Heinz Company
Hurley X-Ray Company
E. R. Squibb & Company
The Borden Company
Gerber Products
Camp Surgical Company
Bilhuber–Knoll Company
Horlick's Malted Milk Corp.
Mellin's Food Company
Kellogg Company
Kremers–Urban
G. D. Searle
White Laboratories
V. Mueller
Winthrop Chemical Co., Inc.
M & R Dietetic Labs.
Lippencott
Roemer Drug Company
Carnation Milk
Saunders Company
Medico Mart
S. M. A. Corporation
Sandoz Chemical Works, Inc.
U. S. Standard Products
John Wyeth Company
Sharp & Dohme
Rudolph Beaver
Conformal Footwear, Inc.
Eli Lilly & Company
C I B A
Phillip Morris

REREGISTRATION AND INVENTORY OF NARCOTICS AND MARIHUANA

Reregistration by July 1.—The attention of all Wisconsin physicians now using narcotics or marihuana in their professional work is called to the requirement that there must be separate reregistration for each executed and filed with the Collector of Internal Revenue, Milwaukee, Wisconsin, together with an annual tax of $1, on or before July 1. While ordinarily a physician will receive a reregistration form both for narcotics and marihuana prior to June 1, he is not excused for failure to reregister merely because he does not get such a form, since it is his duty to make application for reregistration.

Inventory due by July 1.—In addition to reregistering and paying the annual tax, each Wisconsin physician desirous of administering, dispensing, prescribing, giving or transporting narcotics or marihuana, must file a separate inventory of each with the Collector of Internal Revenue, Milwaukee, Wisconsin, prior to July 1. It is the duty of the physician to obtain forms, even though these may not have been forwarded to him by the Collector of Internal Revenue in Milwaukee.

Discontinuance.—A physician now registered under the narcotic or marihuana acts, who for military or other reasons expects to discontinue his practice or the administration of those drugs in the near future, should, if possible, notify the Collector of Internal Revenue of his intention not later than June 30, the close of the tax year. He will receive special instructions as to disposition of his stock on hand. A physician discontinuing his practice or the administering of narcotics or marihuana between July 1, 1943 and June 30, 1944, may retain his stock of narcotics and marihuana in his office so long as each is carefully kept out of ordinary reach, or he may cancel both licenses and dispose of his stock on hand. The preferable procedure for the physician entering military service during the last year would doubtless be to cancel whichever license he may have because of the uncertainty of his return in time for registration for the year beginning July 1, 1943.

STATE OF WISCONSIN

No. 53, A, 1943.

A JOINT RESOLUTION

Urging physicians and dentists to maintain records of services rendered to veterans of the present war.

WHEREAS, It is essential to the recovery of federal war compensation by veterans of the present war that a given disability be shown to have resulted from and in connection with the military service of the claimant, and

WHEREAS, It is also essential to proof of such service-connected disability that all treatment records kept by a physician or dentist of the claimant be available to military and federal authorities, and the absence of such a record may defeat the bona fide claim of a veteran; now, therefore, be it

Resolved by the assembly, the senate concurring, That the state board of health, state board of medical examiners, the state board of dental examiners, and the several professional societies be requested forthwith to ask that all practicing physicians and dentists ascertain, so far as possible, whether patients are now or are on any subsequent date veterans of the present war, and that in the case of each such veteran his case history be preserved for at least 6 years after the date the last professional service is rendered by such physician or dentist. Be it further

Resolved, That each of the above boards and professional societies be further requested to contact all of their respective licensees and members at least once a year for the balance of the war, and at least once each year for the first 6 years following the war, so as to remind all such persons of the importance to the war veterans of preserving such professional records; and be it further

Resolved, That duly attested copies of this resolution be transmitted forthwith to such boards and professional organizations.

Conrad Shearer — PRESIDENT PRO TEMPORE OF THE SENATE.

Vernon W. Thomson — SPEAKER OF THE ASSEMBLY.

Lawrence R. Larsen — CHIEF CLERK OF THE SENATE.

Arthur L. May — CHIEF CLERK OF THE ASSEMBLY.

This resolution was introduced by Assemblyman Lyall T. Beggs, of Dane County, a veteran of the first World War and Past Vice-Commander of the American Legion. It will be printed periodically in *The Wisconsin Medical Journal* during the next several years.

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. E. S. Schmidt, Green Bay, President
Mrs. O. M. Layton, Fond du Lac, President-Elect
Mrs. R. B. Dryer, Poynette, Vice-President
Mrs. R. M. Kurten, Racine, Recording Secretary
Mrs. L. D. Quigley, Green Bay, Corresponding Secretary
Mrs. Charles Fidler, Milwaukee, Treasurer
Mrs. C. D. Partridge, Cudahy, Parliamentarian

COMMITTEE CHAIRMEN

Archives—
Mrs. J. P. Connell, Fond du Lac
Convention—
Mrs. H. O. Zurheide, Milwaukee
Finance—
Mrs. J. R. Minahan, Wauwatosa
Hygeia—
Mrs. A. C. Taylor, Appleton
Philanthropic—
Mrs. S. O. Lund, Cumberland
Press and Publicity—
Mrs. D. B. Dana, Kewaunee
Program—
Mrs. D. F. Gosin, Green Bay
Public Relations—
Mrs. R. D. Champney, Milwaukee
Legislation (special committee)—
Mrs. L. V. Sprague, Madison
Circulation of Bulletin (special committee)—
Mrs. W. A. Wagner, Oshkosh
War Activities (special committee)—
Mrs. A. J. McCarey, Green Bay

County Auxiliary Proceedings

Dane

Wives of medical officers now stationed in Madison were entertained by the Dane County Auxiliary at a tea on May 17 at the home of Mrs. E. F. Schneiders, Fuller's Woods. Mrs. O. L. Rogers and Mrs. L. V. Sprague poured. Hostesses who assisted Mrs. Schneiders were Mrs. R. E. Campbell, Mrs. J. P. Dean, Mrs. H. M. Carter, Mrs. H. E. Marsh and Mrs. H. L. Greene, all of Madison.

Mrs. B. I. Brindley, assisted by Mrs. D. C. Atwood and Mrs. S. J. Briggs, was in charge of refreshments. Mrs. W. C. Keettel was in charge of invitations.

Fond du Lac

Mrs. E. V. Smith, Jr., was elected president of the Woman's Auxiliary to the Fond du Lac County Medical Society at a meeting on April 29 at the home of Mrs. Nora McGauley, Fond du Lac. Other officers chosen are:

President-elect—Mrs. J. S. Huebner
Secretary—Mrs. J. E. Twohig
Treasurer—Mrs. H. A. Devine

Dinner was served before the business meeting by Mrs. McGauley and Mrs. T. A. Hardgrove, the assisting hostess. Bridge was played, and honors went to Mrs. P. G. McCabe, Mrs. J. C. Devine, Mrs. W. C. Finn and Mrs. H. C. Werner.

Kenosha

"Headhunting in the Solomons," a popular new book by Carolyn Mytinger, was reviewed by Mrs. Everett McNeil at a meeting of the Kenosha County Auxiliary on April 6 at the home of Mrs. F. E. Andre, Kenosha. The current news interest in the Solomon Islands made the description of the climate and terrain especially interesting at this time.

At the business meeting, Mrs. C. C. Davin was elected president-elect of the auxiliary. Members heard a report on USO activities which was given by Mrs. Alexander Schlapik, and Mrs. A. L. Mayfield, victory reporter, spoke on the need for WAACS. It was voted to donate $25 to the Red Cross drive.

Red, white and blue carnations and candles decorated the refreshment table at which Mrs. A. M. Rauch, president, poured. Hostesses for the afternoon were Dr. Margaret Pirsch, Mrs. Theodore Sokow, Mrs. S. F. DeFazio, and Mrs. L. T. Kent.

Milwaukee

The eleventh annual meeting of the Woman's Auxiliary to the Medical Society of Milwaukee County was held on Friday, May 14, at the Plankinton Hotel. This was the last meeting of the season, and more than fifty members were present.

After members were welcomed by their president, the meeting was turned over to Mrs. R. D. Champney, program chairman. She introduced Miss Margaret Sharp, executive secretary of the Red Cross, who spoke in behalf of her organization.

"Medicine's Contribution to the War" was discussed in a forceful manner by Dr. Eben J. Carey, dean of the Marquette University School of Medicine and president of the Medical Society of Milwaukee County. He gave his listeners an insight into what the future may hold in the field of medicine. Mr. James O. Kelley, executive secretary of the Medical Society of Milwaukee County, also appeared on the program. His subject was "How to Help Your Husbands Win the War."

The president's annual message was read by Mrs. H. O. Zurheide, who then called upon the chairmen of standing committees for their reports. On behalf of the auxiliary, Mrs. W. M. Jermain presented Mrs. Zurheide with a beautiful gavel in appreciation of her fine work during the year. Mrs. F. R. Janney, incoming president, then accepted the office and pledged her cooperation to the fullest extent for the year to come.

The following slate was presented:

Board Members

Mrs. T. L. Squier
Mrs. U. A. Schlueter
Mrs. G. H. Hoffman

Officers

President—Mrs. F. R. Janney
President-elect—Mrs. E. F. Barta
Vice-president—Mrs. H. A. Heise
Recording secretary—Mrs. C. W. Osgood
Corresponding secretary—Mrs. T. M. Northey
Treasurer—Mrs. R. P. Schowalter

Many members made plans to attend sessions of the Woman's Auxiliary to the American Medical Association, June 7–9, in Chicago.

Outagamie

The Outagamie County Auxiliary has been holding its meetings on the same nights as those of the county medical society, and because the latter did not schedule a meeting last month, there was no May meeting of the auxiliary. No further meetings will be held until fall.

Sheboygan

On May 5, members of the Woman's Auxiliary to the Sheboygan County Medical Society met at the home of Mrs. L. F. Pauly, Sheboygan, with Mrs. G. J. Hildebrand presiding.

Officers elected are:

President-elect—Mrs. J. W. McRoberts
Secretary-treasurer—Mrs. L. F. Pauly

Tea was served after the business meeting, and Mrs. L. M. Simonson read an article on juvenile delinquency.

Society Proceedings

Dane

At the regular monthly meeting of the Dane County Medical Society at the Madison Club, Madison, on Tuesday, May 11, at 8 p. m., a colored sound movie on "The Story of 'Lyovac' Normal Human Plasma" was presented. Speakers at the meeting were Dr. Chester M. Kurtz, Madison, associate professor of medicine, and Dr. John C. McCarter, Madison, associate professor of pathology, both of the University of Wisconsin Medical School. Dr. Kurtz spoke on "Rheumatic Heart Disease," and Dr. McCarter, on "How Rheumatic Heart Disease Behaves."

Members of the Board of Trustees of the Society met at 6:15 p. m., prior to the program.

Attendance at the meeting numbered fifty-five.

Douglas

When the Douglas County Medical Society met on May 5, at 6:30 p. m., at the Hotel Superior, Superior, Dr. Walter E. Hatch, Duluth, Minnesota, delivered an address on "Intravenous and Retrograde Pyelography."

Kenosha

Twenty members of the Kenosha County Medical Society assembled in Kenosha on May 20 at 7 p. m. The special feature of this meeting was a discussion of "Carcinoma of the Uterus." The speaker, Dr. Herbert E. Schmitz, Chicago, is professor of obstetrics and gynecology at the Loyola University School of Medicine, Chicago.

La Crosse

The monthly meeting of the La Crosse County Medical Society was held on Tuesday evening, May 11, at the Hotel Stoddard, La Crosse. Dinner was served at 6:30 p. m.

Dr. Robert W. Keeton, Chicago, spoke on "The Preoperative Preparation of Patients; An Internist's Viewpoint."

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met at the Galesville City Hall on May 20 at 6:30 p. m. Dr. Walter J. Jones, La Crosse, spoke on "Treatments of Fracture." Dr. Arthur L. Van Duser, Green Bay, district health officer, gave an informal talk on "Typhoid Carriers." Twelve members attended the meeting.

The secretary of the Society was instructed to arrange for an orthopedic clinic.

Fourth Councilor District

The Fourth Councilor District Medical Society held its annual meeting at Kaben Cafe Hall in Prairie du Chien on Thursday, May 20, Walter J. Meek, Ph. D., acting dean of the University of Wisconsin Medical School, gave an address on the historic work of Dr. Beaumont, an early army surgeon stationed at Prairie du Chien. Recently a group of physicians and civic officials established the Beaumont Memorial Foundation at Prairie du Chien. This group is sponsoring the preservation of early historic medical records and plans to assemble Beaumont material in this city. Dr. Meek is active in recognizing the valuable scientific work of early Wisconsin physicians.

Dr. Beaumont became famous for his observations of the digestive process through an opening into the stomach of a wounded French Indian soldier, Alexis St. Martin. The physician's accurate observations and data laid the foundation for the science of physiology of digestion.

The remainder of the program consisted of two other speeches and two special movies:

Virus Pneumonia—Major Charles S. Higley, Chief of Medical Service at the Station Hospital, Truax Field, Madison.

The Ulcer Problem—Dr. Harold E. Marsh, Madison.

Studies in Human Fertility—A movie presented through the courtesy of Ortho Products, Linden, New Jersey.

Radium Treatment of Cancer of the Cervix—A movie presented through the courtesy of the Simpson Radium Institute, Chicago.

Following the afternoon program, the physicians, Kiwanis members, and guests were invited to the home of Dr. Henry H. Kleinpell, Prairie du Chien, for a fish fry, after which movies of Japan and of Japan's occupation of China were shown.

Approximately thirty-five doctors, besides the county nurses from the counties in the district, attended the program. Several residents of Prairie du Chien attended the meeting to hear Dr. Meek discuss the life and work of Dr. Beaumont.

Ninth Councilor District

The Ninth Councilor District Medical Society held its annual meeting at Stevens Point on Thursday, May 13. In the afternoon a clinic was conducted at St. Michael's Hospital by Dr. Ira R. Sisk, professor of urology, and Dr. T. C. Erickson, professor of neurosurgery, both of the University of Wisconsin Medical School, Madison, who showed and discussed cases of kidney diseases, epilepsy, and other organic nervous diseases.

Following a six o'clock dinner at the Elks Club, Dr. Erickson spoke on "The Management of Head Injuries," and Dr. Sisk, on "Newer Ideas Regarding the Prevention of Certain Types of Kidney Stones."

News Items and Personals

Members of the Marshfield Rotary Club were addressed by *Dr. Stephen E. Epstein* of the Marshfield Clinic, Marshfield, at the club's weekly dinner meeting on April 19. The subject of his discussion was world government.

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Dr. Gunnar Gundersen, La Crosse, was recently elected president of the State Board of Health, and *Dr. Ira F. Thompson*, Racine, vice president.

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At the Tuesday noon luncheon meeting of the Kiwanis Club, Antigo, *Dr. William P. Curran*, Antigo, discussed "Facts and Fancies about Blood Pressure." He defined blood pressure in lay terms and explained how it is measured. Speaking on the fancies which have arisen about blood pressure, he mentioned several types of food frequently but inaccurately considered to be causes of high blood pressure.

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"Our Eyes and Their Defects" was the subject of a talk by *Dr. Nathan Schneck*, Manitowoc, before the Sheboygan Falls Woman's Club on Tuesday evening, April 13. Dr. Schneck has written material for students and has contributed articles to magazines.

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At the reorganization meeting of the Appleton Board of Health, *Dr. Carl D. Neidhold* was reelected president. Other physician members of the Board are *Dr. Joseph L. Benton* and *Dr. Francis J. Huberty*, city physician.

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Dr. John A. Schindler, chief of the medical staff and director of laboratories at the St. Claire Hospital, Monroe, addressed the Tri-State Hospital Assembly at Chicago during its session May 5, 6, and 7. He illustrated his topic, "Maintenance of Body Fluids in Surgical Patients," with colored slides. Other Wisconsin speakers were *Dr. Edmund H. Mensing*, Milwaukee, and *Dr. Thomas J. Snodgrass*, Janesville.

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Using as his topic "Forty Years a Doctor," *Dr. Thomas Willett*, who has been a practicing physician in West Allis for the past forty years, spoke to the members of the Senior League of the West Allis Methodist Church at their 6:30 meeting on Monday, May 9.

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The health committee of the village board of Sharon has appointed *Dr. Joseph D. Warrick*, a local physician and surgeon, as its health officer. He replaces L. C. Kief, appointed to the office a few years ago, who recently pleaded guilty to a charge of practicing chiropractic at Sharon for the past ten years without a license.

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Dr. Dell Andrus, Ashland, was reappointed county physician by the Ashland County board of supervisors on Tuesday, May 4.

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Dr. Arthur J. McCarey, Green Bay physician and surgeon, was chosen a director of the Wisconsin Anti-Tuberculosis Association at its Thirty-fifth Annual Meeting early in May. Dr. McCarey is president of the board of health of the city of Green Bay.

The Association reelected *Dr. Carl W. Eberbach*, Milwaukee, to the board and named *Dr. Elwood W. Mason*, Milwaukee, a new member of the board.

In a talk to the Association, *Dr. Carl N. Neupert*, State Health Officer, Madison, stated that it

was possible that the stepped-up pace of war work might bring about an increase of tuberculosis in Wisconsin. He said, "The inducements such as extreme patriotism or a desire to take advantage of the attractive wage scales now in force in industry are more than some can resist. Accordingly, individuals who would ordinarily get by under normal exertion or fatigue loads break down under the increased load."

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Members of the Nakoma Pre School and Kindergarten Club, Madison, were addressed by *Dr. Addie M. Schwittay* of the Jackson Clinic, Madison, at their evening meeting on Monday, April 19. The subject of Dr. Schwittay's talk was "General Health of Our Children."

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At the annual staff meeting of St. Michael's Hospital, Stevens Point, on Wednesday afternoon, May 12, the following Stevens Point physicians were elected to the staff:

President—*Dr. Erich Wisiol*
Vice-president—*Dr. Rhody W. Rice*
Secretary—*Dr. Austin G. Dunn*

Members of the Executive Committee:

Dr. Walter A. Gramowski
Dr. E. P. Crosby
Dr. John A. Litzow

The retiring president, *Dr. Wayne F. Cowan*, who indicated that he did not desire to continue to serve as chief of staff, had held his position continuously since September, 1926, with the exception of one year. During his tenure in office, the obstetric department of the hospital was added and the hospital was placed on the accredited list of the American College of Surgeons.

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Dr. Chester M. Echols, Milwaukee, made the presentation speech when a class of 129 Red Cross Gray Ladies received their certificates and veils at St. Joseph's Hospital, Milwaukee, on May 25. This was the largest class of Milwaukee County Red Cross Gray Ladies to be graduated.

Assignments for this new class include Mount Sinai Hospital, St. Luke's Hospital, St. Vincent's Orphanage, and the Milwaukee Maternity Pavilion. A night staff has been added to St. Joseph's Hospital, and approximately twenty-five additional Gray Ladies have been added to the Red Cross blood procurement center for duty with the mobile unit.

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Members of the Mercy Lakeside Alumnae Association, Oshkosh, heard an interesting lecture by *Dr. Raymond H. Quade*, Neenah, at its monthly meeting on May 11. Dr. Quade spoke on the fundamental causes of nervous disorders and diseases frequently encountered in the medical and nursing professions and stressed the importance of suitable environment and social life in the rearing of children and the reflection of such conditions in the personalities, emotions, and later life of those children.

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At a meeting of the Milwaukee Academy of Medicine on Tuesday, May 18, at the University Club, Milwaukee, Dr. Henry T. Ricketts, assistant professor of medicine of the University of Chicago Medical School, discussed aviation medicine, and *Dr. John B. Ludden*, Milwaukee, spoke on sex hormone experiments. The Academy is conducting two essay contests; one on any subject affecting the science of the profession, and another on mental diseases.

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Dr. Edward P. Evans, Milwaukee, a medical examiner of the Equitable Life Assurance Society for fifteen years, was guest of honor at a testimonial luncheon Saturday, April 17, at the Hotel Plankinton, Milwaukee. A gift was presented to Dr. Evans by the agency.

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According to *Dr. Amy Louise Hunter*, chief of the Bureau of Maternal and Child Health of the State Board of Health, Child Health Day this year found more than 2,000,000 boys and girls between 14 and 18 years old working in war plants, stores, offices, restaurants, and on farms. Dr. Hunter said that a physical examination should be given every young person before he is hired for a job in order to determine whether or not he is physically capable of handling his prospective work. She stated, "Regular follow-up examinations will detect weaknesses early and indicate how he is holding up under the job. Since full muscular development is seldom attained before the age of 18, boys and girls should be kept from jobs involving heavy lifting."

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The Minnesota State Medical Association, Minneapolis, at its annual banquet, May 18, was addressed by *Dr. Marcos Fernan-Nunez*, professor of pathology at the Marquette University School of Medicine. His subject, "A Medical Travelogue of Spanish America," was illustrated with lantern slides.

At the general sessions program of the Association on May 19, he gave the featured address, his topic being "Tropical Diseases: A War and Postwar Problem."

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Dr. William F. Lorenz of the University of Wisconsin Medical School, Madison, was one of the speakers at graduation exercises for a class of radio operators and mechanics at Truax Field, Madison, on Sunday, May 16.

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A new addition to the plant medical staff of the Badger Ordnance Works, Merrimac, is *Dr. Le Grand M. Cox*, formerly of Chicago, who replaces Dr. George E. Hildebrand. Dr. Hildebrand volunteered and was accepted in the United States Army medical corps.

Before becoming affiliated with the Badger Ordnance Works medical staff, Dr. Cox was for five years a ship surgeon for a large fruit company, a position which took him to the east coast of South America and to the Central American countries. Shortly after the United States entered the war, he had the experience of being on board his ship while it was chased, unsuccessfully, by two submarines.

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Succeeding *Dr. Harvey G. E. Mallow*, Dr. F. C. Haney has been appointed city commissioner of health of the city of Watertown. Dr. Mallow has been commissioned a first lieutenant in the United States Army Air Force. Dr. Haney has held this position in several past administrations.

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The annual meeting of the Milwaukee Oto-Ophthalmic Society was held on Tuesday, May 11, at the University Club, Milwaukee. *Dr. Frederick A. Davis*, Madison, presented a paper on "A Survey of 500 Consecutive Intracapsular Cataract Extractions," which was accompanied by a moving picture demonstration.

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At the April staff meeting of the Wisconsin General Hospital, *Dr. Ernest A. Pohle*, professor of radiology at the University of Wisconsin Medical School, Madison, spoke on "Indications and Contraindications for Roentgen Therapy."

At the May staff meeting on May 18, *Dr. Lester W. Paul*, associate professor of radiology at the University of Wisconsin Medical School, Madison, lectured on "Fundamentals of Gastrointestinal X-ray Diagnosis."

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The spring meeting of the Wisconsin Academy of Surgery was held Wednesday, May 26, at the Jackson Clinic, Madison. The following subjects were discussed by Madison physicians:

Diaphragmatic Hernia—Dr. Elmer E. Debus.
Cancer of the Large Bowel—a symposium by *Dr. Harold E. Marsh, Dr. Lawrence V. Littig*, and *Dr. James A. Jackson.*
Neurological Interpretation of Acute Head Injuries—*Dr. Albert Bryan.*
Treatment of Burns—*Dr. J. T. F. Gallagher.*
Treatment of Varicose Veins—*Dr. Luther E. Holmgren.*
The Sulfa Drugs in Surgery—*Dr. Arnold S. Jackson.*

Case presentations were made by two groups of Madison physicians.

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The United States Chamber of Commerce and the American Public Health Association, sponsors of the 1942 national health conservation contest, has awarded trophies to Milwaukee, Madison, and Racine in recognition of their superior records in health achievement. This is the sixth year that Milwaukee has won first place in its division.

According to information supplied by the Office of War Information, more than 97 per cent of the Navy men and marines wounded at Pearl Harbor have survived. Stressing the idea that "the wounded don't die," the Office of War Information summed up its findings in these words: "Never before in the history of the world has the fighting man had available the medical care and equipment the United States now furnishes."

The Army's hospital system is unified from the battalion aid station right behind the line to the great hospitals in this country, a chain which has served to cut the war toll to a great extent. Moreover, men have often been picked up on the field of battle and flown to this country and have been able to telephone their families before the report of their wounding has reached this country. The possibility that a man in service can reach home within a few days from any part of the world serves as a powerful morale builder.

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At the regular meeting of the Clinical Society of the New York Polyclinic Medical School and Hospital held on Monday, May 3, at 8:30 p. m., the following program was presented:

The Sulfonamides—James P. Croce, M. D.
Blood Pressure and the Total Individual—John Carroll, M. D.
The Treatment of Paroxysmal Tachycardia and Auricular Fibrillation—Harold E. B. Pardee, M. D.
The Management of Lung Abscess—George G. Ornstein, M. D.
Apocrine Breast Cancer (colored motion pictures)—Herbert C. Chase, M. D.
Evaluation of Excretion Urography as Compared with Instrumental Urography—Joseph F. McCarthy, M. D.
Gastroduodenal Ulcer; Its Surgical Approach—Robert E. Brennan, M. D.
The Hypertonic Infant—Sidney V. Haas, M. D.
Premature Babies—W. Morgan Hartshorn, M. D.
Endometrial Implant Occurring in Abdominal Scar Following Cesarean Section—Edward H. Dennen, M. D.
The Treatment of Empyema as a Postoperative Complication—Henry I. Goodman, M. D.
Three Simple Tests for Bedside and Office Diagnosis of Liver Diseases—Samuel Weiss, M. D.
The Status of Gastroenterology in Medicine—G. Randolph Manning, M. D.

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The June 1, 1943, issue of *Look*, nationally known pictorial magazine, continued its series of articles on "Fighters on the Home Front" with a five page feature entitled "Your Doctor Meets a War Health Crisis." *Dr. Harry A. Keenan*, age 66, Stoughton, the Wisconsin doctor chosen by the magazine as the nation's typical home-front doctor, is pictured

throughout the pages of the article in various activities at his office, at the hospital, at a draft board examination, and at his home at the end of the day.

Forsaking all leisure, Dr. Keenan averages five hours of sleep a night as he untiringly carries on his own work as well as assists in carrying on that left behind by two Stoughton doctors who have enlisted. A captain in the last war but now in the medical reserve inactive ranks of the Army, he claims that he has never been more active in his life and insists that he will never retire but will "die in the harness." *Look* says that "Our men in white are showing us that not all heroes are fighting in the foxholes."

Speaking of the need for steps to be taken to remedy the shortage of doctors in order to prevent a serious breakdown of the nation's health, the magazine states: "Throughout the nation, 10,000 communities like Stoughton must also 'make do' with less medical care. In many sections, the shortage has become critical. But with the American people lending a hand, our supply of doctors more evenly distributed, and men like Dr. Keenan unswervingly devoted to their calling, we can hold our own for the duration." The magazine calls attention to the work being done by the War Manpower Commission's Procurement and Assignment Service in alleviating the shortage throughout the nation.

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Dr. Vincent G. Springer, Omro, president of the Winnebago County Medical Society, left Friday, April 23, for Winnetka, Illinois, where he will be associated with a group of physicians in that city. Dr. Springer has been practicing physician in Omro during the last three years. Prior to that time he was located at Winneconne for about five years.

BIRTHS

A daughter, Dorothy Estelle, to Lieutenant and Mrs. Robert C. Dana, Fond du Lac, on November 4.

A daughter to Dr. and Mrs. M. H. Wirig, Madison, on April 30.

DEATHS

Dr. L. L. Hines, 72, a Richland county physician for over thirty-five years, died Friday, May 21, at his home in Richland Center. Here he had carried on an office practice for the past six years. Previously he had practiced for a period of thirty years at Rockbridge, his birthplace.

He is survived by his widow.

Dr. William F. Hilger, 69, for forty years a practicing physician and surgeon in Milwaukee, died Saturday afternoon, May 22, following a brief illness.

Born in Menomonee Falls, he taught school in his early youth at Sauk Center, Minnesota. Later he attended Valparaiso University, Valparaiso, Indiana, where he earned a degree in pharmacy. He was graduated from Milwaukee Medical College in 1903. In 1914 he went to Harvard University, where he studied surgery.

Surviving him are his widow, three daughters, a son, two sisters, and a brother.

Major Jacob J. Horwitz, 50, Milwaukee, died at Hot Springs, Arkansas, on Saturday, April 24. Before being commissioned in the medical corps last January, Major Horwitz was a practicing physician in Milwaukee. He was attending gynecologist and obstetrician at Mount Sinai Hospital and was a diplomate of the American Board of Gynecology and Obstetrics. He was a graduate of Rush Medical College.

At the time of his death, Major Horwitz was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by three sisters, all of Milwaukee.

Dr. Glenn L. Baker, 67, Rib Lake, died Sunday, April 11, following a heart ailment with which he was first stricken in 1938.

Dr. Baker, a native of Wood Lake, Minnesota, was a graduate of Hamlin University, St. Paul, Minnesota, and the Northwestern University Medical School. He had served Rib Lake as a physician from 1922 until his retirement in 1940, with the exception of a year's practice in Westby.

Survivors are his widow, a daughter, a brother, and a sister.

Dr. Frank B. Lansdowne, 67, Kenosha, died April 19 after an illness of four weeks.

He was born December 19, 1875, in Louisiana, Missouri, the son of pioneer residents of that community. He received his early education in the schools of that vicinity and continued his education at Washington University, St. Louis, from which he received his medical degree. He took postgraduate work at Columbia University and was an interne at the Bellevue Hospital, New York City. He started his medical career in Kenosha in August, 1898, and practiced there continuously until the time of his death. For several years he served as coroner of Kenosha County and participated in various community activities. He was on the staffs of St. Catherine's Hospital and the Kenosha Hospital.

Surviving Dr. Lansdowne are six daughters, one brother, and fourteen grandchildren.

Dr. David D. Mehigan, 52, a police surgeon in Milwaukee since 1924, died Monday, April 26, following an operation. A native of Milwaukee, he was a graduate of the Marquette University School of Medicine, where he was a star football player for three years. After serving his internship at St. Mary's Hospital, Minneapolis, he began practicing medicine in his home city in 1914. He served as a

lieutenant in the medical corps of the Army during World War I.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Dr. Mehigan is survived by three brothers.

Dr. Frank B. Farnsworth, 80, the senior member and one of the founders of the Munn–Farnsworth Clinic, Janesville, died Wednesday, May 5, after an illness of several weeks. He had practiced at Janesville for forty-five years.

He was born in 1863 at St. Albens, Vermont. When he was two years old, his family moved to Janesville. He was graduated from the Northwestern University Medical School, Chicago, in 1898. At the time of his death, he was a member of the Rock County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Dr. Richard J. Muenzer, 68, Milwaukee eye, ear, nose, and throat specialist for thirty years, died Tuesday, April 18.

Dr. Muenzer studied medicine at the University of Wisconsin Medical School and at the Wisconsin College of Physicians and Surgeons, from which he was graduated in 1900. Following his graduation, he practiced at Wabeno for one year and at Allenton for nine years. After their marriage in 1910, he and Mrs. Muenzer spent two years abroad. During this time he studied in Vienna, Berlin, and London to become a specialist. Since his return to this country, he had practiced in Milwaukee.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, four daughters, five sons, and one sister. Four of his sons are serving in the armed forces.

Dr. Bernard L. Campbell, 89, Milwaukee, one of the first physicians and surgeons in Waukesha County, died at his home Monday, April 26.

Dr. Campbell, who was graduated from the Northwestern University Medical School, Chicago, in 1884, is followed in the profession by two sons, both of whom survive him. One is a Wisconsin physician, Dr. Edward J. Campbell; the other, a physician in Ohio, Dr. Roderick M. Campbell. Besides the two sons, his widow and a daughter survive him.

COMING EVENTS

International College of Surgeons

For the coming Fourth International Assembly of the International College of Surgeons which is to be held at the Waldorf Astoria Hotel in New York City on June 14, 15, and 16, and which will deal with the subjects of "Rehabilitation" and "War Surgery," the tentative program arrangements are as follows:

1. Papers will be read by eminent authorities in the Grand Ballroom during both morning and afternoon sessions.
2. Continuous round-table discussions on Rehabilitation, War Surgery, Care of Veterans, and allied subjects have been scheduled to run for the duration of the Assembly.

Visitors to the Assembly are urged to view the many exhibits which will be set up to demonstrate activities in military medical affairs and rehabilitation. Among these will be a visual demonstration on the work of the State of New Jersey Rehabilitation Commission. John J. Toohey, Jr., director of the Commission, will present its Curative Workshop under the personal direction of Mr. J. C. Kupper.

The Veterans Administration, Washington, D. C., will furnish charts showing pictures and descriptions of the routine and special measures in bibliography, occupational therapy, and physical therapy used to aid in the treatment of patients in Veterans Administration Hospitals.

The Medical Detachment of the 17th Regiment, New York State Guard, wil set up a regimental aid station. The personnel will consist of members of the medical detachment who will be in daily attendance. There will also be an exhibit by the Bureau of Services for the Blind of the New York State Department of Social Welfare. A large number of motion pictures in color will be shown on Craniocerebral Surgery, Bone and Joint Surgery, Plastic Surgery, and War Surgery.

Many distinguished visitors from all parts of the Americas are expected to attend.

Upper Peninsula Medical Society

The Forty-Sixth Annual Meeting of the Upper Peninsula Medical Society will be held on Wednesday, July 14, at Iron Mountain, Michigan.

SOCIETY RECORDS

New Members

W. H. Zahl, 101 Main Street, Whitewater.

J. G. Waddell, 2609 University Avenue, Madison.

J. M. Wilkie, Wisconsin General Hospital, Madison.

E. W. Niles, Whitewater.

V. J. Taugher, 1505 North 27th Street, Milwaukee.

Lewis Danziger, 1545 South Layton Boulevard, Milwaukee.

R. L. Rice, 735 North Water Street, Milwaukee.

Changes in Address

H. W. Pankow, Oconto, to 8030 Harwood Avenue, Wauwatosa.

H. T. Schroeder, Wauwatosa, to 138 West Locust Street, Milwaukee.

F. B. Mead, Madison, to 3616 Main Street, Riverside, California.

News of the Neighbors

Offense is the Best Defense

"In its fight against disease organized medicine has maintained one fundamental principle, that is, it has carried on the fight in an offensive effort. . .

"An army of medical men trained to this degree is a strong offensive front against disease. Of course, when disease attacks the public the medical man is first on the defensive, but it does not require much time for him to begin the offensive type of battle which emerges in so many victories. . .

"By applying the above principle to organized medicine, which is now suffering from a tremendous malignant condition, such as state medicine, socialized medicine, insurance medicine, or call it by whatever name you please, this plan of battle should be carried out. . . We have waited until attacked instead of anticipating what was being done to destroy medicine as we have known it; therefore let us set our forces to work, destroying the attack before it gets a malignant grip upon the medical profession. . .

"Inasmuch as our colleagues who are in the armed forces are waging an offensive battle against our enemies, let us begin an offensive campaign against the enemies who would destroy medicine as we have known it. Let us do this in order that we may be able to preserve the medical rights of those in the armed forces and to save our past and present method of practising medicine."—From the President's Page of the May, 1943, issue of *The Journal of the Indiana State Medical Association.*

Postgraduate Medical Education

". . . Some physicians have advised a discontinuance of postgraduate medical education for the duration of the war. Their reasons for this advice are: Many of our members are in the armed forces and the numbers attending will be reduced. Teachers and physicians are carrying an additional load of professional work and will have little time for postgraduate study.

"Although these arguments are undoubtedly valid there are more weighty reasons why the program should be continued. Many men are now returning to the active list of practicing doctors of medicine. They will welcome the knowledge of modern medical treatment and they will be far safer physicians because of it. At the successful conclusion of the present war our professional members will expect to find the *Michigan Plan of Postgraduate Medical Education* in operation. Both the specialists and the general practitioners will seek suitable refresher courses before or soon after resuming their practice. We must not fail them."—From the President's Page of the March, 1943, issue of *The Journal of the Michigan State Medical Society.*

A Charitable Act

"The physician still clings to his own concept of charity. He does not regard his services as a right to be demanded as a gift, nor does he wish his help to be forced on the recipient. His voluntary and brotherly act is sympathetically given and without ostentation. The physician is interested in the effect achieved as it relates to the person in need rather than the personal benefit he will derive from his benevolent action. May organized medical effort for the benefit of the public never become so mechanically perfect that this point of view is lost among our rising generation of physicians.

"Government can play a part in this achievement. The aim held by the physician is the same as when he first started the interest in and succor to those in need who could not themselves provide it. Government should never cause the physician to sacrifice the aim originally sought, but can assist in making the achievement of this aim possible on a wider scale through the development of better methods of distribution and through financial support of the services necessary to accomplish this aim."—An Editorial from the April, 1943, issue of *The Journal of The Medical Society of New Jersey.*

Concerning Projected Hospitals for the U. S. Public Health Service

"Information has also been received that Washington authorities are planning for hospital structures of permanent nature, to be erected in Pacific Slope States, the administration of which is to be under the auspices of the U. S. Department of Public Health.

"The issues involved in the above are important to physicians, especially with reference to medical practice in the future. The subject is of sufficient moment to be worthy of consideration by the C. M. A. House of Delegates, when it convenes in annual session at Los Angeles, on May 2, 1943."—From an editorial in the April, 1943, issue of *California and Western Medicine.*

The First Tooth

"The doctor reached for his hat and bag with a sigh of relief. Now at last he could run home for a bit of supper and a chance to relax in his chair by the radio. He was tired—unusually tired. Loss of sleep and a strenuous day's work had taken its toll on his reserve energy.

"As he opened the door to leave the office, the telephone rang. He started to disregard its insistent call but the force of habit was too strong.

" 'Hello,' he growled, as he lifted the receiver.

" 'Dr. Jones, I'm so glad I caught you before you left the office.' It was a young woman's voice at the other end of the line. 'This is Sally—Sally Baker, you know. You remember I called you last night about Patsy, about how fretful she had been for the past two days,' the words were pouring out now, 'and you said you didn't think it would amount to anything. Well, you were wrong. The most wonderful thing has happened. Patsy has cut her first tooth. Couldn't you run by on your way home and take a look at it?'

"The physician was speechless. The whole world was at war, American soldiers and sailors were fighting on foreign soil to preserve the four freedoms, he and all others at home were asked to work as never before—and now at the end of a hard day's work he was asked to stop and 'goo and ga' over a baby's first tooth.

" 'What the ____,' he started to shout—and then he paused. Sally Baker—Sally Johnson she was when she lived across the street. It seemed only yesterday that she was in high school—carefree as any young puppy. After graduation she had married Johnny Baker, her childhood sweetheart. Came Pearl Harbor and John had donned the uniform. One month before the baby came, Johnny had sailed for Africa. A tremendous ache had been left in Sally's heart, but no one would have known it. Sally smiled, and she had kept on smiling. She knew what the world was going through. She knew what sacrifice meant—but she kept on smiling, particularly after Patsy came. Johnny was thousands of miles away but some day he would be coming home—home to Patsy and to her. How she must be longing to share the baby's first tooth with Johnny—but Johnny wasn't there and so Sally turned to little Patsy's next best friend—her doctor.

"The doctor straightened his shoulders. As long as there were Sallys and Patsys in the world, life would always be worth living.

" 'That's wonderful, Sally,' the physician replied. 'I'm not only delighted but I am complimented. I'll be right there.'

" 'I wonder what he meant by being complimented,' Sally mused as she placed the receiver back on the hook and turned to the crib where Patsy lay cooing."—From the editorial page of the April, 1943, issue of *The Journal of the South Carolina Medical Association.*

O. P. A.

"The medical practice will be affected by the rationing of some types of foods which, of necessity, are important to the welfare of certain types of patients who need selected diets, i.e., diabetes, et cetera. I have been told that individuals have come to the rationing boards with certificates for selected foods which are out of all reason. These certificates are purported to have been signed by physicians. The members of the board have been very gracious, but they think that many of these certificates have been forged, while, of course, many have been bona fide signatures. Physicians should exercise good judgment when they issue certificates for extra rationing points in order to get the proper diet for patients who cannot obtain proper food from unrationed products.

"An advisory staff has been set up by the state association to help the O.P.A. select a minimum and maximum amount of rationed food to be issued to these patients. This staff will serve to guide the amount of legitimate food points to go to patients who are truly in need of them. Therefore, let us all be cautious in issuing such certificates to patients." —From the President's Page of the April, 1943, issue of *The Journal of the Indiana State Medical Association.*

". . . the physician's wife"

"The medical profession is on trial and if we are to emerge victorious in our battle against regimentation it must be done through an educational program, for little does the public realize the evils of government medicine. When the committee in whose hands we have entrusted the future planning for our State Association agrees upon a program, I sincerely trust they will not overlook the potential strength of the members of the Woman's Auxiliary, for they are willing and anxious to be of service. Where can be found a more devoted ally than the physician's wife? Let's give them a chance to help us."—From the President's Page of the May, 1943, issue of *The West Virginia Medical Journal.*

Sixteen Named to Study Health Insurance

"Mayor La Guardia appointed yesterday a committee of sixteen, headed by himself, to study and report on a comprehensive plan of medical and health insurance for persons of moderate income. . .

"Mayor La Guardia announced several weeks ago, in one of his Sunday radio broadcasts from City Hall, his intention to establish a city-wide system of medical and health insurance, under city sponsorship. The committee now appointed, he said, would be known as the City Committee to Study Plan to Provide Medical Service for People in Moderate Group.

"The health and medical plan will function, it was indicated, through a panel of physicians set up by a non-profit membership corporation. Subscribers to the plan, by payment of a fee, would become entitled to stipulated medical service, including treatment, operations, nursing care and other facilities. In his broadcast the Mayor suggested that the existence of the plan would make it easier to absorb into routine medical activities New York physicians returning from service with the armed forces after the war.

"Although the plan will not be a municipal enterprise, the city will make available its own experience and resources in any way legally possible, the Mayor said."—From the April 23, 1943, issue of *The New York Times.*

". . . progress rather than stand-pattism"

" 'To promote public health and to effect a wider distribution of medical care in this state by authorizing corporations not for profit to establish and operate medical care plans for the benefit of subscribers making periodic payments.' This is the preamble to an Act of the Ohio State Legislature by which we, as organized Doctors of Medicine, are permitted to bring to the great mass of our people the finest and best medical care ever developed in the World. Not even Michael Davis, who admits he knows all the answers, has ever found fault with the quality of American Medicine today. This famed Ph.D., expert of the first National Health Conference and the A.M.A. trial, said that 'American Medicine travels on a bicycle and Social Medicine in an airplane.' If we apply this trite utterance to the distribution of medical service I am quite sure the learned expert has something.

"Scientific medicine has made such trepid strides in the last two decades and we all have been so busy in our attempts to keep up, that we have left Social Medicine in the little red school house. While we have fiddled the Farm Security Administration, in conjunction with the Rehabilitation Committee, have set up a prepaid medical service plan in Logan County. I commend for your collateral reading —'Industry Pioneers in Medical Care' as condensed from Forbes magazine and appearing in the current issue of the Readers Digest.

"This week marks the 90th Annual Meeting of the Ohio State Medical Association. Despite our depleted ranks and the fact that everyone of us is working much harder than in normal times, it is important that every physician make an effort to attend this meeting. We should instruct our delegates to the American Medical Association to support the resolution adopted by the Conference on Medical Service in Chicago. This resolution provides for a Medical Bureau in Washington—a bureau, not a paid lobby, which will fulfill Senator Burton's request for a group to whom the Congress and government officials may turn for actual, factual and timely information on medical questions. In other words, somebody who knows what it is all about.

"There is only one way to get the American Medical Association to adopt such a policy as provided for in this resolution. We must select A. M. A. delegates from Ohio and every other progressive State Medical Association who are cognizant of this changing world and who will fight for progress rather than stand-pattism.—A. A. Brindley, M. D." —from the President's Corner of the April, 1943, issue of *The Bulletin of The Academy of Medicine of Toledo and Lucas County.*

An Insurance Man's Viewpoint Toward Current Social Security Proposals

"*The New York Times* in the issue of Feb. 15, 1943, reported extracts from a speech delivered by Secretary of Labor Frances Perkins before a specially invited audience at the New School for Social Research, in New York City, on the subject of an amendment to the Social Security Law which would provide for an immediate expansion to include benefits for temporary disability for accident and sickness, hospitalization, maternity, etc., along the lines of the so-called Beveridge Plan.

"This talk was commented on by a weekly insurance journal (The Eastern Underwriter of New York) which stated in part 'that she (Miss Perkins) thought insurance companies are "well disposed toward the plan."'

"No such reference is included in the article in the *Times*, but if the statement attributed to her is true, the writer would be very much interested in having a list of those Insurance Companies. Surely it could not include any companies writing Accident and Health Insurance because it would seem that such companies would be as well disposed toward this plan as a condemned prisoner might be toward a hangman who was adjusting the noose around his neck.

"Since this talk was made the House of Commons in England has voted to postpone action until the war is over and this is in line with the best thought in this country so far as this amendment is concerned.

"There will be, according to present plans, some 10,000,000 or 11,000,000 men in the armed services by the end of 1943, and this is the generation which would live under such a law. Is it fair to them to rush through drastic legislation of this kind in their absence and without the benefit of their advice and opinion? England says "NO" and the proper answer in this country to this 'cradle to grave' legislation should also be "NO."

"So far as the Insurance Business is concerned it would seem that a matter so important should be discussed and debated thoroughly after the Peace has been won, and then if it is decided that such a law would be for the benefit of the majority of the people of this country the Insurance Interests would gladly bow out and sacrifice any personal interest to the general good. Just now it seems that every dollar should be devoted to the winning of this war and it is by no means won yet. If this measure is necessary to prevent inflation, then inflation is already here.

"Miss Perkins states that 'we can do it now. We can do it very shortly, and we can do it painlessly, because we have the trained personnel and the system to do it.' It is conservatively estimated that it would require a minimum of 260,000 additional employees to administer the act. In view of the manpower shortage, where in the world does she expect to find them? Grave doubt is expressed that she has a trained personnel set up to handle the tremendous volume of detail required in the administration of this act. Our national payroll this year is estimated at something like $80,000,000,000, so that the Social Security Board would have the tremendous

task of setting up this extensive plan and handling the infinite details involving a premium income of $8,000,000,000.

"She further states that the estimated cost is about 10% and presumably 5% would be allocated to the employer and 5% to the employee. As an employee put it to the writer, 'I have a salary of $2,000. Presumably I will have to pay last year's income tax amounting to 19%, having no deductions and I may have to pay-as-you-go this year, which would be another 19%. I am already having deducted from my pay, 5% Victory Tax, 1% Social Security Tax and 10% for Bonds, or a total of 54% leaving me only 46% of my actual pay. If the Social Security is increased as outlined, there would be an additional 4% or 5% which would run my total deduction this year to 58% or 59%, leaving me only 41% or at the most, 42% of my earnings for my living expenses.'

"While certain labor leaders have spoken in favor of this extension, it is believed that the rank and file of labor will be opposed to an increase in the already heavy deductions made from their present pay envelope, when they realize that they are not getting something for nothing. Again it is proper to inquire on what statistical data the proposed rate of 10% was based. The public is as yet uninformed on this important point.

"It would seem, in absence of proof to the contrary, that this is the opening attack on all private enterprise and that once this system is in force there will be just as good reasons advanced for the entrance of the government into all other lines of insurance leading eventually to the socialization of all industry.

"That is why those who do not favor this plan are in opposition to it—not from a selfish viewpoint, but with the object of safeguarding the institutions that our armed forces are fighting to preserve—the opportunity afforded by free enterprise.

"This far reaching and revolutionary legislation would seem to require much further deliberation and study before it is translated into law. So far as can be determined, no real demand for it exists except as it has been artificially created from Washington by propaganda and ballyhoo. The watchword should be 'caution.' "—From the May, 1943, issue of the *Westchester Medical Bulletin.*

Doctors to Study Effect of the War

"In the belief that out of the war social and economic changes are bound to develop, the New York Academy of Medicine has named a committee of distinguished doctors and laymen to study the relationship of medicine and the changing order. . .

"An announcement of the formation of the group explained that the committee would solicit the cooperation of men and women intimately connected with medicine, such as deans of medical schools, teachers of medicine, hospital and public health authorities and clinicians, those interested in graduate education, medical social workers and workers in voluntary health organizations.

"The objectives of the committee are given as follows:

" 'To be informed on the nature, quality and direction of the economic and social changes that are taking place now and that are clearly forecast for the immediate future; to define in particular how these changes are likely to affect medicine in its various aspects; to determine how the best elements in the science of medicine and its services to the public may be preserved and embodied in whatever changed social order may ultimately develop.'

"The committee, which also will confer with sociologists, economists, representatives of organized labor, industrialists, bankers and politicians, said it would welcome suggestions from anyone 'who might propose sources of information which would aid it in this study.'

" 'We wish to emphasize that the committee will devote itself primarily to the study of how, within the changing social order, the best qualities of medical service, in medical education and in medical research, can be preserved and developed,' the announcement said.

"The group will be known as 'The Committee on the Study of Medicine and the Changing Order.' "—From the April 19, 1943, issue of *The New York Times.*

Trade News

More Help for Milk-Allergic Patients

Appetizing and nutritious recipes for using Mull-Soy in milk-free diets are now available in a new publication of Borden's Prescription Products Division. Already widely prescribed as a hypoallergenic substitute for milk in infant formulas, Mull-Soy is now proving equally useful in diets of older infants, children, and adults who are allergic to milk.

Mull-Soy is an ethically marketed soybean food in liquid emulsified form. It is palatable, readily digestible, well tolerated, and easy to use. Although hypoallergenic in most cases of milk allergy, it nevertheless closely resembles milk in nutritional values of protein, fat, carbohydrate, and minerals. Mull-Soy ingredients are entirely of nonanimal origin, consisting of soybean flour, soybean oil, soybean lecithin, dextrose, sucrose, calcium phosphate, calcium carbonate, salt, and water. After special processing at carefully controlled temperatures, the mixture is homogenized at high pressure, sealed in sanitary cans, and sterilized. In flavor it is slightly

sweet and nutlike, and many find it makes a pleasing warm drink when simply diluted with an equal amount of hot water.

Included in the new Mull-Soy recipe folder are numerous beverages, soups, and desserts, as well as directions for using Mull-Soy in place of milk or cream for cereals, coffee, mashed potatoes, etc. Each recipe has been carefully tested in the Borden Experimental Kitchen and checked for palatability, ease of preparation, and suitability for milk-free allergy diets. A number of the recipes have several suggested variations and optional ingredients which permit greater variety in the diet and also make the recipes more useful for patients allergic to other foods in addition to milk.

These Mull-Soy recipe folders are designed for distribution by physicians to their patients. Any desired number of copies may be obtained by writing to Borden's Prescription Products Division, Department CB, 350 Madison Avenue, New York 17, N. Y.

Pediatric Antiques on Tour

It has been well said that more progress has been made in pediatrics during the past three or four decades than in all the time before that.

As applied to the feeding part of pediatrics, the Mead Johnson Collection of Pediatric Antiques bears eloquent witness to the great strides made. Without such evidence, it would be difficult, indeed, to imagine our own grandparents being fed from some of these odd-shaped utensils that defied thorough cleansing. To be sure, sterilization and pasteurization were not then in vogue. Not all babies received breast milk in abundance. In the days when wet nurses were common, some of these enterprising women literally did a wholesale business, managing to nurse three or four infants.

The baby's cereal of a century ago was simply stale bread lightly boiled in water, wine or beer. Butter or sugar might be added, but the use of milk was regarded as fraught with danger. It was thought, according to Dr. T. G. H. Drake, "Milk might bring on the watery gripes, or the infant might imbibe with the milk the evil passions and frisky habits of the animal supplying the milk."

From a personal hobby enjoyed by the late E. Mead Johnson, Jr., the Collection of Pediatric Antiques, illustrated in the pages of a catalogue just issued, has evolved into one of considerable historic importance, depicting as it does the progression of infants' feeding vessels from the Greece of twenty-five centuries ago down to time within our own memory.

The collection has been steadily growing in size and scope and is of increasing interest for teaching purposes via the historic route. The destruction of original sources caused by the war tends to add to the value of these objects.

Hence it is that, by request, the collection now goes on an annual pilgrimage to colleges, hospitals, museums, libraries, and other institutions of learning. Arrangements may be made for "stop-overs" upon application to the curator. Mead Johnson & Company, Evansville, Indiana.

Murray Breese Associates Celebrates Tenth Anniversary

The first complete advertising agency to consider physicians and the ethical drug field as a definite and separate market celebrated its tenth anniversary this month.

The agency is Murray Breese Associates of New York, with offices in St. Louis and Chicago. For the last decade the Breese organization has been offering complete agency service to manufacturers of ethical pharmaceuticals, surgical supplies, and fortified foods. New products are developed through laboratory stages and clinical evaluation down to copy, art, and marketing. Validity of advertising claims is stressed, and, in addressing physicians and other professional people, a conscious effort is made to lean toward conservatism.

Professional accounts serviced by Murray Breese Associates include those of Parke Davis & Company, Ciba Pharmaceutical Products, Inc., Bristol-Myers Company, William R. Warner & Co., Inc., Mallinckrodt Chemical Works, Singer Sewing Machine Company, and Cocamalt.

Winthrop Chemical Company Announces Appointment

Maurice L. Tainter, M. D., professor of pharmacology, Stanford University, and also professor of pharmacology and head of the division of physiologic sciences, College of Physicians and Surgeons, San Francisco, has been named research director of the Winthrop Chemical Company, Inc., according to an announcement by Dr. Theodore G. Klumpp, president.

The appointment implements the policy of research expansion by Winthrop, Dr. Klumpp said. Dr. Tainter will make his headquarters at the company's plant and laboratories in Rensselaer, New York.

In addition to his university associations, Dr. Tainter has been serving as a consultant on chemical warfare to the San Francisco War Council and also as state gas consultant for the California State Council on Defense. In these two capacities, Dr. Tainter has been actively interested in the organizational side of chemical warfare defense.

Vitamin Bc

Isolation and crystallization of the antianemic Bc vitamin—half a million times more potent than fresh liver—which may speed convalescence from many illnesses because of its blood regenerating effects, was announced by scientists of Parke, Davis & Company, world's largest pharmaceutical house.

The announcement, contained in the April 30 issue of *Science*, describes the new vitamin Bc as definitely a member of the vitamin B complex.

The subletter "c" has been added to the name to represent the thousands of chicks on which experimental studies have been made.

CORRESPONDENCE

April 21, 1943

Mr. C. H. Crownhart
Secretary, State Medical Society of Wisconsin
Madison, Wisconsin

Dear Mr. Crownhart: I had not seen the supplement to the April number of *The Wisconsin Medical Journal* when your letter of April 15 was received. However, since that time I have seen the supplement, and I am not at all surprised that there has been such a large demand for it.

A tremendous interest in the general subject of nutrition has been created, but I am afraid that some of this interest has developed as the result of a constant bombardment on the ears and eyes of the public by manufacturers and promoters whose statements are sometimes without any scientific foundation. That being so, it seems to me that it is altogether desirable for the organized medical profession to provide reliable, authentic information for the benefit of the public.

Very sincerely yours,
(Signed) OLIN WEST, M. D.
Secretary and General Manager
American Medical Association

April 23, 1943

Mr. C. H. Crownhart, Secretary
State Medical Society of Wisconsin
Madison, Wisconsin

Dear Mr. Crownhart: We are enclosing our check for $1.00 and would appreciate receiving ten copies of the reprint "Extra Ration Points for Special Diets."

This is an excellent brochure with extremely valuable information that will save many hours of work for physicians and also rationing boards. May I offer my congratulations to be added to those which you will doubtlessly receive from other sources.

Very truly yours,
(Signed) W. H. BARTLESON
Executive Secretary
Jackson County Medical Society

April 29, 1943

State Medical Society of Wisconsin
Madison, Wisconsin

Messrs:

The diet supplement to the April number surely was a swell idea. Our ration board wants to keep mine. Could I please have another one?

Will gladly pay the price whatever it may be.

Yours truly,
(Signed) DR. T. D. SMITH
Neenah, Wisconsin

May 2, 1943

C. H. Crownhart, Secretary
State Medical Society of Wisconsin
Madison, Wisconsin

Dear Charles Crownhart:

The information in your letter of yesterday relative to the passage of the bill providing for the annual reregistration of physicians in the state was most gratifying.

You especially, with other officers of the Society who have worked so diligently for the passage of this bill are to be congratulated upon your success and I bespeak my appreciation both as a member of the Board and personally for the time and effort spent in accomplishing this very satisfactory result.

Very sincerely yours,
(Signed) JESSIE P. ALLEN, M. D.
Beloit, Wisconsin

May 3, 1943

Wisconsin Medical Journal
Madison, Wisconsin

Gentlemen: I have recently seen a reprint of your article, "Extra Ration Points for Special Diets," and have been impressed with the service which you have rendered the physicians of your state.

If these are available for distribution to out-of-state doctors, I should appreciate very much your sending me three copies—one for my personal use and two for our County Medical Library. Kindly bill me for whatever charges are involved.

Yours very truly,
(Signed) ROYALL M. CALDER, M. D.
Internal Medicine
1203–07 Medical Arts Bldg.
San Antonio, Texas

May 13, 1943

Mr. George B. Larson, Assistant Secretary
The State Medical Society of Wisconsin
Madison, Wisconsin

Dear Mr. Larson:

We had an interesting time last week, and we have learned a lot.

The experience has been very much worth while and I want to again thank you, Secretary Crownhart, and all others who made it possible to meet with you.

These Clinics (Industrial Medical and Surgical Clinics) have done a real job!

I judge that from the mail that has come in and is still coming. There seems to be an unusual interest as a result of the Appleton meetings.

I feel sure a good industrial health and safety program can be put over in a big way in Wisconsin.

Your fine organization, with the cooperation of others, has paved the way, and now it is a question of following through.

As I said in Appleton, never in my experience have I seen a program so well organized and handled, with every detail taken care of.

You have done a masterful job and are entitled to worlds of credit.

Often we attend meetings around the country and we find those in charge of the programs have overlooked just those things that go to make the whole undertaking a success.

You have a splendid following among those who attended the Clinics and rightfully so because of the excellent work you have done and are doing.

I hope soon to thank you in person in behalf of Wisconsin industry.

With sincere regards and all best wishes,

Cordially,

(Signed) W. D.

W. D. James, President
James Manufacturing Co.
Fort Atkinson, Wisconsin

THE PRESS

Chiropractor Fined

"Lester C. Kief, local chiropractor who has been practicing without a state license in this village since the forepart of 1931, a period of twelve years, pleaded guilty to the offense in county court at Elkhorn Monday morning. Judge Roscoe R. Luce imposed a fine of $100 and costs, or 60 days in the county jail. The defendant paid the fine. . .

"The judge questioned the defendant concerning his activities relative to practicing here at the present time. Kief stated that he had discontinued his practice and was at present employed in a Beloit defense plant. He also informed the court he had taken down a sign advertising his profession at his home, although the sign remained in place for several weeks following his arrest last January. He also told the court he was studying in preparation for again taking the basic science examinations in the state, and that he expected to do so sometime in June. He failed to pass these examinations in 1930 when he failed in three of the four subjects.

"The minimum fine was imposed by the judge, who stated that he thought society was satisfied by such a penalty. That was cheap—less than $8.50 a year for an illegal practice which no doubt took thousands of illegal dollars from the pockets of an unsuspecting public in this community." From the *Sharon Reporter*, April 15, 1943.

Health and Socialism

"Northwestern University has just published a report, based on an exhaustive study made by members of its staff, of compulsory health insurance in the United States. The report should be read by every American citizen. It warns of dangers inherent in social schemes that envisage government as the sole dispenser of medical care at the expense of the general taxpayer. It stresses the need for treading cautiously lest in a hasty grab for Utopia, social and economic progress be lost and medical standards irretrievably lowered.

"In its practical application, compulsory health insurance reverses the normal doctor–patient relationship. At present the patient is anxious to get well and get back to work. The doctor too is anxious to secure quick recovery for his patient. He knows that big doctor bills and lengthy illness do not contribute favorably to his reputation in the patient's mind. Under compulsory health insurance, the patient is paid by the government(tax-payers) for being sick. The longer the sickness, the more he receives. A 'good' doctor is liberal in certifying clients as eligible to receive cash benefits. On the other hand, an ethical doctor often arouses the antagonism of clients by refusing unjustifiable benefits. Under the pressure of 'free money' the integrity of patient and doctor inevitably deteriorates. This is a fact borne out by experience in nations having compulsory health insurance.

"Aside from a tendency to lower medical standards, compulsory health insurance would be one more irrevocable move toward socialism. Its advocates openly admit that it is but a short step from there to total government domination of medicine. Socialized medicine would result in a vast expansion of bureaucracy, and human nature being as it is, the doctors themselves would be forced to become politicians as a requisite of success. No longer would medical skill be the sole criterion of advancement." From the *Janesville Gazette*, April 9, 1943.

BIBLIOGRAPHY OF POLIOMYELITIS

A project which will make The National Foundation for Infantile Paralysis the only complete central, authentic source of information on infantile paralysis in the world was announced recently by Basil O'Connor, president of the Foundation.

A complete bibliography of all scientific literature that ever has been published pertaining to infantile paralysis is being compiled by the Foundation and is expected to be ready for publication in book form in the early part of 1944.

THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

When Doctors Are Rationed. By Dwight Anderson, director, public relations, Medical Society of the State of New York, and Margaret Baylous, therapist, Charleston General Hospital, Charleston, West Virginia. Cloth. Price, $2. Pp. 255. New York: Coward–McCann, Inc., 1942.

This text covers a multitude of subjects, some of which do not appear to be too closely related to the general subject of doctor rationing. It is an appeal to the layman to insist upon the free selection of physician, and seems to be a request to the doctor-paying public to continue with its present practice of calling a doctor and considering the proposition as a private transaction.

The book covers such things as, "How to Avoid Fakes and Quacks"; "When You Go to the Hospital"; "How to be a Good Patient"; "How to Choose a Doctor"; and "The Mechanics of Rationing." The authors go on to say that, ". . . *after the war, unless the practice of medicine is handed back to the doctors of the country freely for them to run without government control, medical care may deteriorate, as it has done in other countries.*" Another section of the publication covers the medical needs for civilian defense and makes a strong plea to the public to cooperate with the medical profession for the conservation of energies and services.

This text is timely and in good taste. It is well written and informative. In addition, it has an interesting introduction by Nathan B. Van Etten, M. D., past-president of the American Medical Association, who goes into some details of historic interest.

I feel that Dwight Anderson and Margaret Baylous have done a very good job in clearly delineating the status of the physician as it is at present and prognosticating the physician's future status with the problems presenting themselves. It is deserving of a large sale. L. R. C.

Fundamentals of Psychiatry. By Edward A. Strecker, M. D., Sc. D., F. A. C. P., professor of psychiatry and chairman of the department, Undergraduate School of Medicine, University of Pennsylvania; psychiatrist to the Pennsylvania Hospital; attending psychiatrist, psychopathic division, Philadelphia General Hospital. Cloth. Price, $3. Pp. 201. Philadelphia: J. B. Lippincott Company, 1942.

After a brief historic introduction, the problem of etiology in psychiatry is discussed. The author sees the need to distinguish between preponderantly physical and preponderantly psychic causes. However, he stresses the complexity of the etiologic factors. A chapter on "The Mental Stage of Psychiatric Examination" contains valuable psychologic discussions. It is followed by a description of the organic, toxic, functional psychoses, psychoneuroses, and the defect reaction types. Under this heading the author surmises mental deficiency and the so-called constitutional psychopathic inferiority. The discussion of schizophrenia is illustrated by case histories. The dynamics of the psychoneuroses are explained and different points of view ventilated. A great deal of attention is paid to the different forms of therapy suitable for the individual type of reaction. A short discussion, "The Psychiatry of the War," forms the last chapter in which experiences of the first World War and the present war have been merged.

This handbook is outstanding because of its clarity in style and thought, a feature sadly missed in many books dealing with the difficult problems of psychiatry and psychology. It has three other advantages: It is attractively written, demanding the reader's interest; it is brief, but penetrates below the surface of problems; it is broadminded, not adhering to any dogmatic school of thought. I feel the aim of the author, which I quote from the preface, has been fulfilled: "It is my hope that the compact form of this book will enable the reader to obtain with a minimum of time a workable picture of the field of psychiatry—knowledge which constantly can be interwoven with his work." F. K.

Human Pathology. By Howard T. Karsner, M. D., professor of pathology, Western Reserve University, Cleveland, Ohio. Ed. 6, completely revised and reset. Cloth. Price, $10. Pp. 817, with 460 illustrations. Philadelphia: J. B. Lippincott Company, 1942.

This sixth revised edition of a well known pathology textbook has numerous deletions and additions to the text and bibliography and new illustrations, some of which are in color, though many of the old pen and ink drawings are retained. The type and format are new. However, the general character of the previous editions is retained, since the text represents a summary of pathology by a single author. The preponderance of references is to readily available publications in English—an altogether fitting and proper emphasis.

A certain reportorial style and apparently hurried organization is evident, and this leads frequently to oblique exposition or inadequate treatment. A larger amount of subject material thus is covered at the expense of orderly portrayal of fundamental pathologic processes. J. C. M.

Hypo for an Embryo

ONE of the scourges of war was in retreat before a shot was fired in World War II . . . Vaccine to protect against typhus could be prepared in quantity sufficient for all. In the Lilly Laboratories farsighted planning had provided extensive experience with typhus Rickettsiae, and the yolk sac culture method was a workaday procedure. Within a few short days after war began, vaccine production was increased a thousand-fold. No order has been refused and no fighting man denied typhus protection because of inadequate knowledge or lack of facilities for vaccine preparation.

ELI LILLY AND COMPANY · INDIANAPOLIS, INDIANA, U. S. A.

Lilly

BUY WAR BONDS AND STAMPS

The 1942 Year Book of General Medicine. With 6 associate editors. Cloth. Price, $3. Pp. 848, illustrated. Chicago: Year Book Publishers, 1942.

This compact volume, edited by the country's outstanding authorities in the various fields of internal medicine, contains concise, but not too brief, abstracts of the leading articles which have appeared in the medical literature between July, 1941, and July, 1942. The subject of chemotherapy is well treated and the subject brought up to date in a clear and direct manner. The newer concept of the role of the kidney in essential hypertension is well presented, and the important experimental contributions in this field are given in logical and easily understandable fashion. Diseases of the blood and blood-forming organs are particularly well covered. The book is packed with practical suggestions for both diagnosis and treatment of all medical conditions, and the editors' notes interspersed throughout are full of meat. In the opinion of the reviewer, this is an excellent reference book on general medicine, which gives all the information one requires in most instances, but whenever more detail is desired on any one subject, the original reference for each paper abstracted is readily available. C. M. K.

A Textbook of Gynecology. By Arthur Hale Curtis, M. D., professor and chairman of the department of obstetrics and gynecology, Northwestern University Medical School; chief, gynecologic service, Passavant Memorial Hospital, Chicago. Ed. 4, reset. Cloth. Price, $8. Pp. 723. Philadelphia: W. B. Saunders Company, 1942.

This excellent textbook has been thoroughly revised and brought up to date by the author. The chapter on Anatomy of the Female Pelvis and Perineum is beautifully illustrated. Sulfonamide therapy in gonorrhea and puerperal infections is duly emphasized. Sterility in women is covered in one short compact chapter which reviews the causes of infertility, diagnostic methods and subsequent management. A section on Tumors of the Ovary has been rewritten.

This book can be recommended as fulfilling all the requirements of medical students and furnishing a thorough review or refresher course for the practitioner. M. J. T.

Manual of Standard Practice of Plastic and Maxillofacial Surgery. Prepared and edited by the Subcommittee on Plastic and Maxillofacial Surgery of the Committee on Surgery of the Division of Medical Sciences of the National Research Council, and representatives of the Medical Department, U. S. Army, Cloth. Price, $5. Pp. 432, illustrated, Philadelphia: W. B. Saunders Company, 1942.

This book has been given a great deal of discussion by the plastic surgeons throughout the country. It serves the purpose for which it was published very well, namely, to aid the general surgeons in their care of the wounded of the armed forces of the U. S. Army, but it is hardly meant to be a text for young surgeons specializing in plastic surgery. V. B. H.

Reprints and Bibliography on Oxygen Therapy. Loan packet available upon request from the Medical School of the University of Wisconsin. New York City: The Linde Air Products Company, June, 1942.

The eleven pamphlets included in this packet should prove useful and instructive to any physician. Indications for inhalation therapy as well as the principles and technic of administration are covered in the collection. A very extensive bibliography is included. R. M. W.

Clinical Diagnosis by Laboratory Methods. A Working Manual of Clinical Pathology. By James Campbell Todd, Ph. B., M. D., late professor of clinical pathology, University of Colorado School of Medicine; and Arthur Hawley Sanford, A. M., M. D., professor of clinical pathology, University of Minnesota (The Mayo Foundation); head of division on clinical laboratories, Mayo Clinic. Ed. 10, thoroughly revised. Cloth. Price, $6. Pp. 911, with 380 illustrations, 32 in colors. Philadelphia: W. B. Saunders Company, 1943.

This book remains a favorite with teachers, students, medical technologists and physicians. It contains about seventy more pages than the previous edition because of the inclusion of a large amount of new material and many new illustrations, three of which are in color. A few obsolete methods have been dropped.

Significant changes are the addition of a number of new methods in clinical chemistry, a new, officially recommended, serodiagnostic test for syphilis, known as the Mazzini test, the fluorescent dye method for staining tubercle bacilli, a discussion of the significance of porphyrins in the urine as well as a discussion of the significance of hemoconcentration, methods for determining the quantity of sulfonamides and sulfones in the blood as well as for the identification of sulfonamide crystals in the urine, a description of the Quick prothrombin test and a description of Brewer's new methods for growing anaerobic bacteria. W. H. J.

Autonomic Regulations. Their Significance for Physiology, Psychology, and Neuropsychiatry. By Ernst Gellhorn, M. D., Ph. D., professor of physiology, University of Illinois College of Medicine. Cloth. Price, $5.50. Pp. 373, with 80 illustrations. New York: Interscience Publishers, Inc., 1943.

This book deals not with the functions of isolated organs but with the mutual relationships of the various organs and how any change in either the internal or external environment affects the various organ systems of the body. The necessary adjustments are carried out largely by the autonomic nervous system. The book then has to do with organic physiology.

The first part of the book deals with the characteristics of the sympathetic and parasympathetic systems. This is followed by the bodily adjustments to carbon dioxide, anoxia, asphyxia, hemorrhage and hypoglycemia. Autonomic endocrine and autonomic somatic integrations are then taken up. The book concludes with applications to pathologic physiologic conditions, general and spinal anesthesia and mental disorders.

ACCEPTED AMERICAN MEDICAL ASSN.

LACTOGEN

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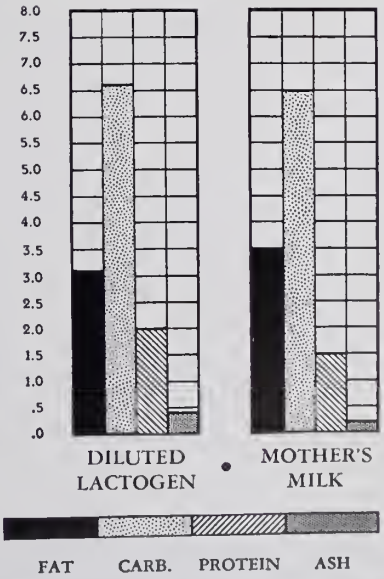
The cows' milk used for Lactogen is scientifically modified for infant feeding. This modification is effected by the addition of milk fat and milk sugar in definite proportions. When Lactogen is properly diluted with water it results in a formula containing the food substances — fat, carbohydrate, protein, and ash — in approximately the same proportion as they exist in woman's milk.



For feeding directions and prescription blanks, send your professional blank to "Lactogen Dept." Nestle's Milk Products, Inc., 155 East 44th St., New York, N. Y.

"My own belief is, as already stated, that the average well baby thrives best on artificial foods in which the relations of the fat, sugar, and protein in the mixture are similar to those in human milk."—John Lovett Morse, A. M., M. D., Clinical Pediatrics, p. 156.

NESTLÉ'S MILK PRODUCTS, INC.

155 EAST 44TH ST., NEW YORK, N. Y.

Dr. Gellhorn has presented an erudite discussion of all the functions and relations of the autonomic regulations. The book is not easy reading, but it is full of meat for one who is willing to give it serious attention. The summaries at the end of the chapters are very helpful. The bibliography contains 1,100 references. W. J. M.

The Reichert Collection—Handbook. Diagnostic Instruments and Techniques in Medicine. A guide to the study of the objects in the collection assembled by Philip Reichert, A. B., M. D., F. A. C. P., New York, for use as a reference laboratory by investigators interested in the field of methods and apparatus. Paper. Complimentary to members of the medical and allied professions. Pp. 71, illustrated. New York: Wellcome Exhibition Galleries, 1942.

This small book should be of interest to the clinician as well as the laboratory worker. The collection includes instruments of sphygmography, sphygmomanometry, auscultation, microscopy and endoscopy. The evolution of the various instruments is taken up in detail, and the advantages and disadvantages of each instrument are adequately discussed. To those who are interested in the historic aspects of the development of the instruments and technics of physical diagnosis this book is recommended. J. L. B.

The Anatomy of the Nervous System. By Stephen Walter Ranson, M. D., Ph. D., formerly professor of neurology and director of Neurological Institute, Northwestern University Medical School, Chicago. Ed. 7. Cloth. Price, $6.50. Pp. 520, with 408 illustrations, some colored. Philadelphia: W. B. Saunders Company, 1943.

The seventh edition of this text is written like the previous ones for the novice in neurology. The length of the text has been increased to cover the advance in the science of neurology, without increasing the complexity of the material presented. As in previous editions, the wealth of illustrations are up to brilliant modern standards and are easy to interpret. The most extensive revisions have been made on the sections dealing with the cerebellum, diencephalon, sympathetic nervous system and blood supply of the cerebral cortex.

The section on the cerebellum has been rewritten to conform with the modern understanding of the anatomy and physiology of the cerebellum. An interpretation of the known connections of the cerebellar nuclei with the brain stem is presented.

The chapter on the sympathetic nervous system has been rewritten and placed in a more logical position immediately following the section on the spinal nerves.

In the chapter on the diencephalon, the thalamic nuclei of the thalamus proper are presented in a clear and concise manner. The connections of these nuclei with the cerebral cortex and the terminations of the various ascending pathways in the thalamus are discussed in an intelligible manner consistent with modern investigations. There has been included in this chapter an account of the anatomy, physiology, and function of the hypothalamus based on modern investigations.

The usual brilliant simplicity of the previous editions of this book has not been sacrificed although the advances in the science of neurology have been adequately covered. As usual, the book has been written especially for and remains an ideal neurologic text for medical students. J. H. R.

Medical Parasitology. By James T. Culbertson, assistant professor of bacteriology, College of Physicians and Surgeons, Columbia University. Cloth. Price, $4.25. Pp. 285, illustrated. New York: Columbia University Press, 1942.

This well organized, well illustrated book presents concisely the facts concerning the animal parasites of man which the medical student and the physician should know. Details of morphology of the parasites (adults, larvae and ova), sufficient for diagnosis, are given without the minutiae which are the delight of the parasitologist but an unnecessary bane to the medical student.

Paragraph headings make the book easy to use. Excellent are the tables summarizing our knowledge of sources and modes of infection, geographic distribution, procedures in diagnosis, etc. Technical methods are given briefly in an appendix.

The format is excellent; both the author and the publisher merit commendation. P. F. C.

A Textbook of Clinical Neurology. By Israel S. Wechsler, M. D., clinical professor of neurology, Columbia University, New York; neurologist, The Mount Sinai Hospital; consulting neurologist, The Montefiore and Rockland State Hospitals, New York. Ed. 5. Cloth. Price, $7.50. Pp. 840, with 162 illustrations. Philadelphia: W. B. Saunders Company, 1943.

The fifth revised edition of "A Textbook of Clinical Neurology," with an introduction to the history of neurology by I. S. Wechsler, New York City, needs no recommendation. The previous editions have fulfilled the requirements of a textbook for students and practitioners. In this fifth edition, valuable information is given as to chemotherapy of meningitis and to brain tumors. The knowledge of organic and psychogenic "headaches" is well presented. The wide clinical experience of the author

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ınd his contact with medical students made possible :he presentation of not only neurologic but also of ıeuropsychiatric problems in such fashion that a ;ood understanding and knowledge of neuropsychia- ric topics, including various types of therapy, can ›e obtained from the book.

The book is well illustrated. It gives sufficient in- :ormation in its drawings for a good comprehension ›f neuroanatomic, neuropathologic and clinical :orrelation.

I regret that an important disease entity, toxo- ›lasmicencephalomyelitis, has been omitted.

Among the more recent textbooks of clinical ıeurology, Wechsler's book maintains its prominent ›lace since it not only includes pure clinical neu- ·ology but also bridges the discussion of the psy- :honeuroses and allied conditions over into the field ›f psychiatry. H. H. R.

Nasal Medication. A practical guide. By Noah D. Fabricant, M. D., M. S., associate in laryngology, rhinology and otology, University of Illinois College of Medicine. Cloth. Price $2.50. Pp. 122, illustrated. Baltimore: The Williams & Wilkins Company, 1942.

This little book presents the subject of nasal medication in a compact, precise manner in slightly more than 100 pages. It is well written and to the point. The section on nasal physiology is excellent. The commonly used nasal drugs are discussed as to their effect on ciliary action and effect on the nasal mucous membranes. There is an excellent chapter on methods of applying nasal medications. I particularly liked the description of the Proetz displacement method.

This book is recommended to specialists in the fields of rhinology and allergy and to general men as well. J. M. W.

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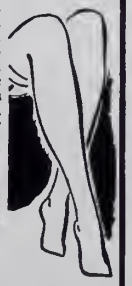

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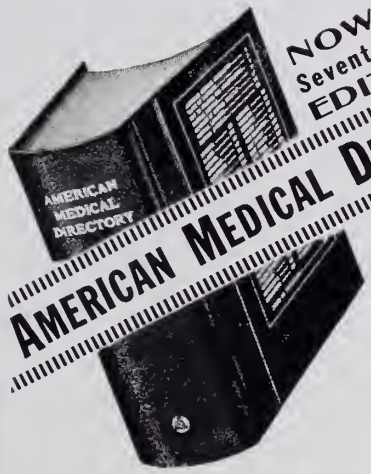

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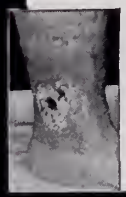

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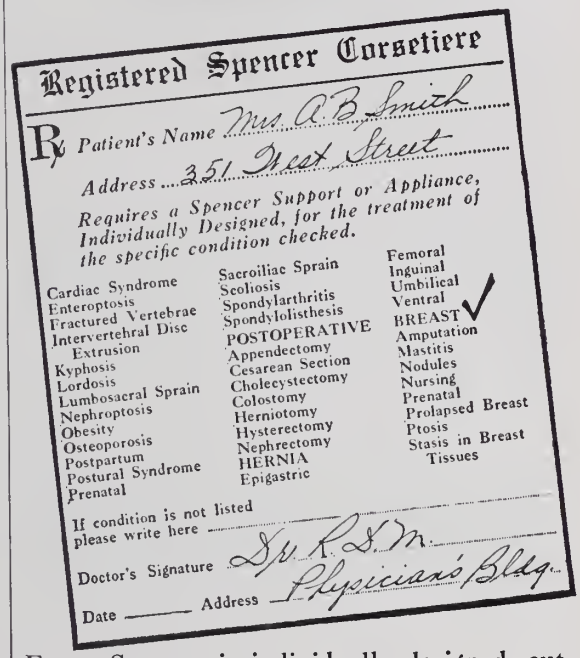
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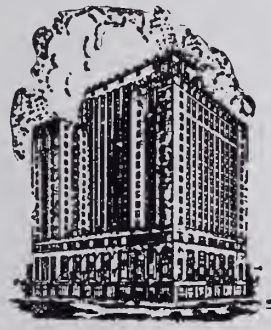

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The Wisconsin Medical Journal

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By Ira R. Sisk, M. D. and Philip M. Cornwell, M. D.

THE CESAREAN SECTION PROBLEM IN WISCONSIN
By Roland S. Cron, M D.

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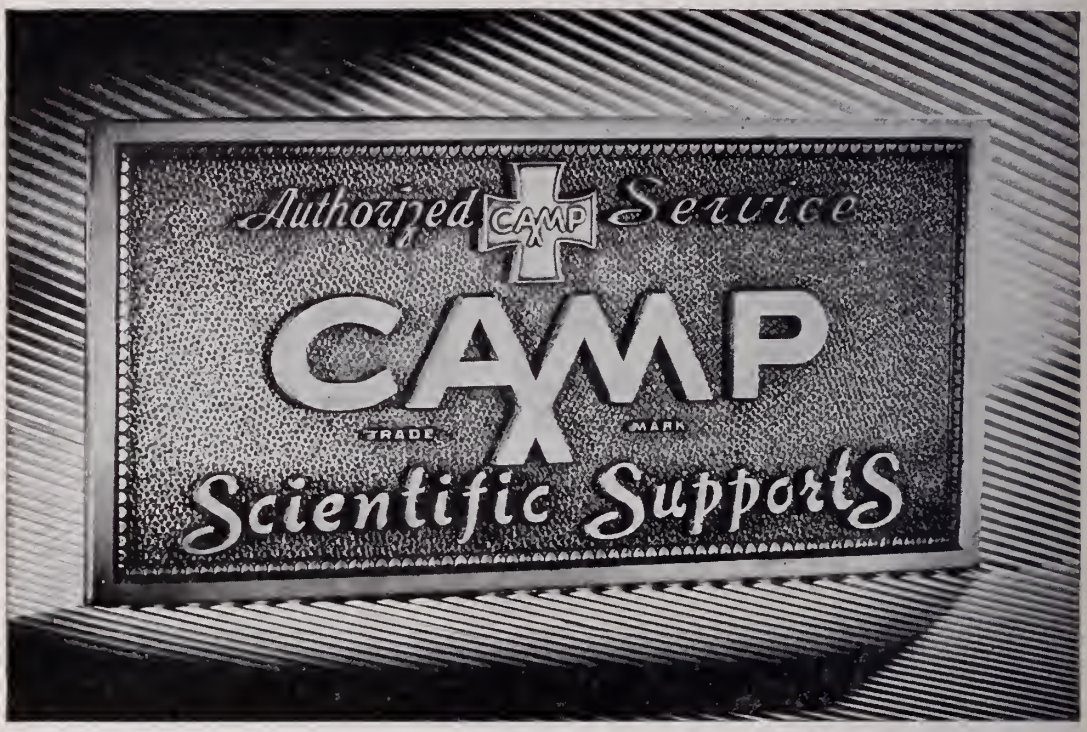

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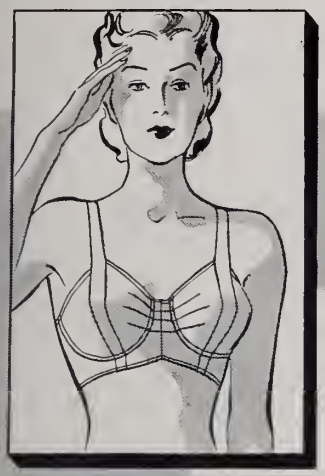

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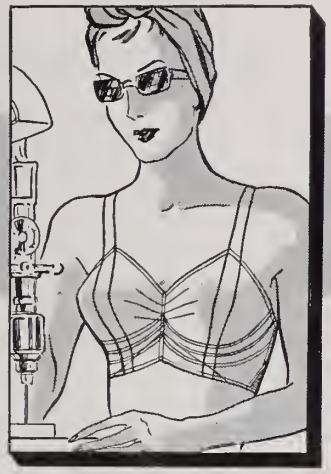

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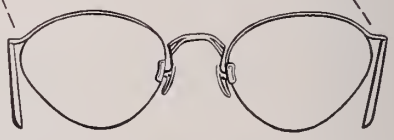

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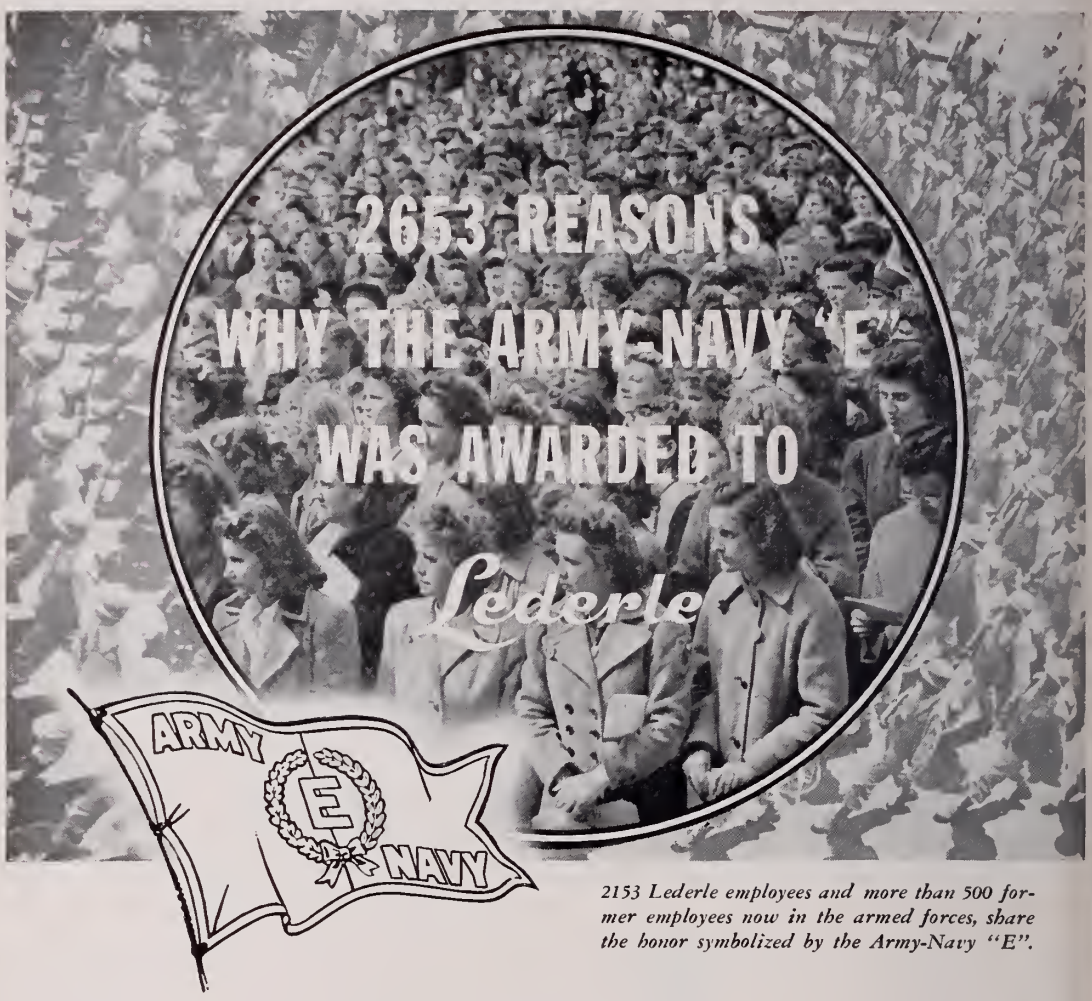

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*Brockbank, William: The Dyspeptic Soldier. Lancet, Jan. 10, 1942.

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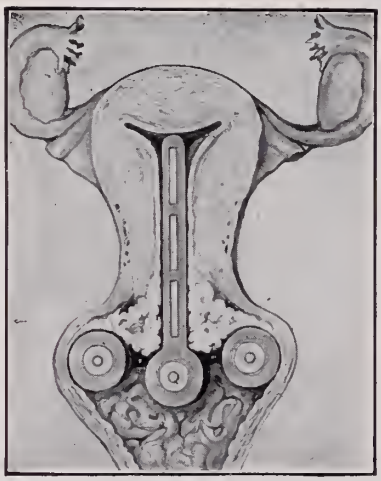

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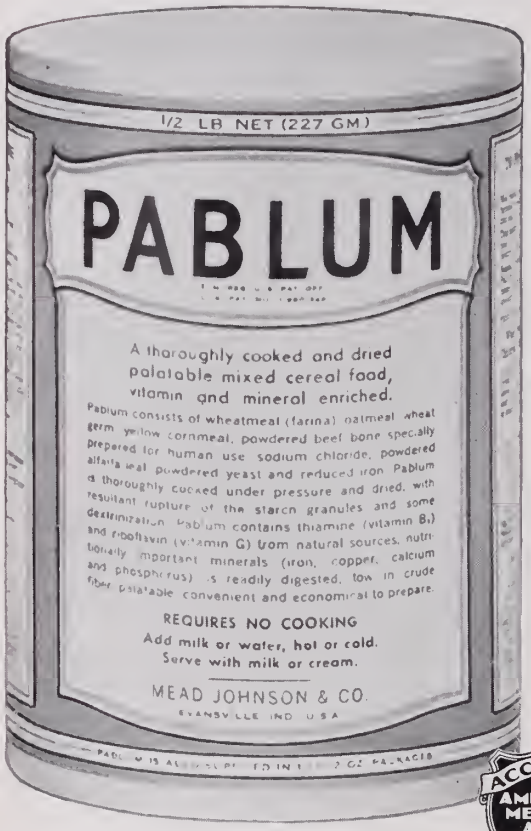

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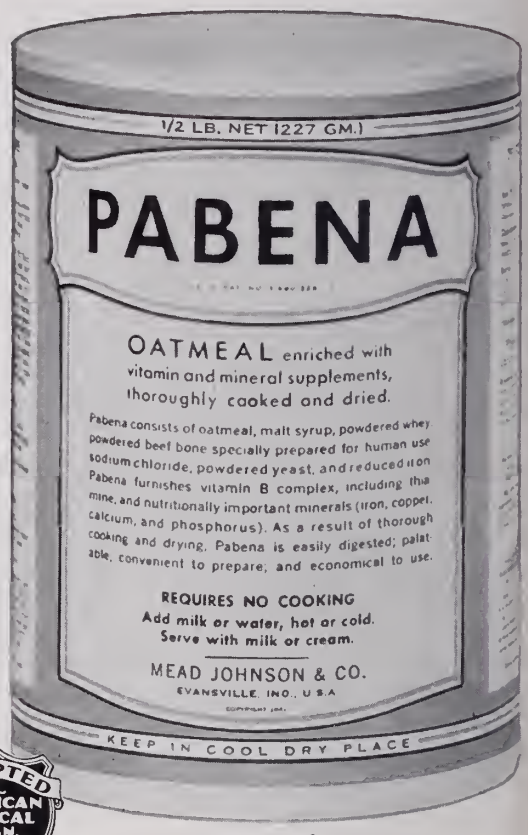

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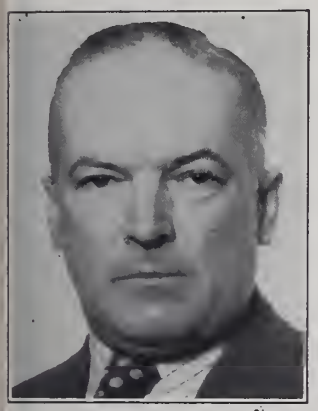
Prostatic Surgery at the Wisconsin General Hospital, 1940-1941*

By IRA R. SISK, M. D., and PHILIP M. CORNWELL, M. D.
Madison



I. R. SISK

Dr. Sisk, professor of urology at the University of Wisconsin Medical School, Madison, received his M. D. degree at the Vanderbilt University School of Medicine, Nashville, Tennessee, in 1916. He is treasurer of the State Medical Society of Wisconsin.

Dr. Cornwell is instructor in urology at the State of Wisconsin General Hospital.

THE genitourinary service at the Wisconsin General Hospital deals almost exclusively with charity patients. With very few exceptions, the private patients of our visiting staff are cared for at another hospital. Our patients, therefore, come almost entirely from the lower economic levels of society and for this reason probably represent, from the physical standpoint, a more than ordinarily neglected group. Many are severely malnourished and dehydrated when they appear for treatment.

During the two years from January 1, 1940, to January 1, 1942, 421 persons were admitted to this hospital suffering primarily from benign prostatic hypertrophy or carcinoma of the prostate. Of these, 381 eventually received some sort of surgical treatment of the prostate gland. The operative mortality in this group was 2.3 per cent. Forty patients were not operated upon, and 6 of these died. In this latter group are three distinct classes of patients: first, those in whom the slight degree of hypertrophy and the virtually complete lack of symptoms made operation unwarrantable; second, those whose condition was so poor (usually patients with chronic uremia) that operative intervention was postponed after relief of obstruction until sufficient improvement for surgery was attained; and, last, those who were admitted in a dying condition from which it was impossible to revive them.

Eighty-seven of the 421 patients, or 20.6 per cent, were suffering from carcinoma of the prostate. The average age of these was 69.7 years. The average age of the patients with benign hypertrophy was 67.7 years. As would be expected in a group of men of this age, a large number of these patients suffered from one to several more or less severe disabilities, mostly of a degenerative nature, which were not connected with their prostatic disease but which necessarily complicated its treatment. Arteriosclerosis, with its manifold manifestations, was almost a routine secondary diagnosis. In 69 patients renal decompensation was present as attested by an elevation of the nonprotein nitrogen of the blood to above 45 milligrams per cent. In 101 cases there was definite evidence of reduced cardiac functional capacity, while in many others there was electrocardiographic evidence of myocardial damage. Forty-five of the above mentioned 101 cases, those with reduced cardiac function, had a functional damage of grade three or worse, on the basis of grade one being the least observable functional impairment and grade

* Presented before the One Hundred First Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1942.

four indicating evidence of failure at complete rest. One hundred eighty-six persons had arterial hypertension, that is, a systolic pressure of more than 150 or a diastolic pressure of over 100. Other complications ran nearly the whole gamut of diseases from diabetes and peptic ulcer to bronchiogenic carcinoma and lymphatic leukemia. Although the existence of hernia is of little importance in most instances, it is interesting to note that 121, or 28 per cent, of these men had this defect, possibly as a result of long continued straining in order to start the urinary stream.

In the discussion of the treatment of these cases, the benign and the malignant lesions will be considered separately.

Benign Hypertrophy

A total of 334 cases were diagnosed as benign hypertrophy. Three hundred and sixteen of these were operated upon with an operative mortality of 2.2 per cent. Among the 18 patients who were not operated upon were 4 who had minimal symptoms, a very small residual urine, and a small gland which did not warrant operative treatment. Eleven others were in such very poor condition that surgery was contraindicated, and they were relieved of their retention either by intermittent catheterization or an inlying catheter. These expedients were in several instances all that could be offered, as the deaths of these patients from varied causes was expected daily. In other instances patients were discharged following catheter drainage, with the expectation that they would subsequently improve sufficiently to allow a reasonable chance of successful operation. In these two groups fall 2 men over 80 years of age, each of whom had worn suprapubic tubes for years and were apparently getting along very nicely in this way, and another who was admitted in coma with a nonprotein nitrogen of 250 milligrams per cent and other chemical aberrations in proportion. This man was readmitted at a later date after prolonged catheter drainage with a nonprotein nitrogen stabilized in the sixties and in vastly improved general condition. He was subjected to a transurethral resection and made an uneventful recovery thereafter. Another malnourished, dehydrated patient with chronic uremia and a severe secondary anemia was started on the road to rehabilitation and discharged with an inlying catheter, with the understanding that he should return for surgery when his general condition had improved. Three individuals died before they could come to surgery: one in uremic coma, one of arteriosclerotic heart disease with congestive failure, and one of severe sepsis.

Transurethral Resection

Two hundred sixty-two of these benign cases were treated by transurethral resection. Among these there were six deaths, a mortality of 2.6 per cent. Forty-two cases, or 16 per cent, required more than one stage. Only 3 cases had three stages, and none had more than three. The average amount of tissue removed transurethrally was 18 grams, with a range from 0.7 to 87 grams. The largest amount removed in one sitting was 82 grams. The average resection patient had a fever which went above 100 F. on four and one-half days during his hospitalization. At least half of this period of fever occurred before operation. With very few exceptions, patients were not discharged until they were voiding normally, were afebrile, and had a residual of not more than one ounce of relatively clear urine. The average hospitalization in this group was twenty-two days. This includes the 54 patients who had multiple stage resections or a resection plus a second unrelated operation. If these cases were excluded, the average hospitalization would be twenty and three-tenths days, with an average postoperative stay of ten days. Section and ligation of the vasa were carried out in only a few who required prolonged preoperative catheter drainage or who had very highly infected urinary tracts. Epididymitis was, nevertheless, a relatively rare complication and occurred only eight times, or in 3 per cent of the cases. In no instance could it be said to be a serious complication. Only 1 patient was incontinent following resection, and he was an uncooperative individual with an extreme degree of senile dementia who would be expected to be incontinent under any circumstances.

Perineal Prostatectomy

Forty-four cases were treated by perineal enucleation of the prostate. In this group of cases there were no deaths. The average weight of the tissue removed was 68 grams. The average patient who had undergone perineal prostatectomy had a fever which went higher than 100 F. on five and eight-tenths days. He was hospitalized twenty-five and one-half days on the average and was discharged on the eighteenth post-operative day. Only 1 patient was discharged with urinary drainage still continuing from the perineum, and only 1 patient was incontinent at the time of discharge. The former had a chronic lymphatic leukemia which undoubtedly interfered with his healing powers, and the latter was the victim of advanced cerebral arteriosclerosis and Parkinson's syndrome. The large majority of these patients had no urinary drainage from the perineum at any time during their convalescence.

Suprapubic Prostatectomy

Nine cases were treated by suprapubic prostatectomy. This operation is confined to those individuals who for some reason or other are not suitable candidates for either of the other two. The most common reasons are ankylosis of the hips, which makes it impossible for the patient to assume the necessary position, or a previous suprapubic cystotomy done elsewhere for an unusually large obstructing gland. In this group one death occurred from massive pulmonary embolus on the fifteenth postoperative day. These patients averaged forty days in the hospital, twenty-five of which were post-operative. Six of these operations were done in one stage, and three were two stage procedures.

In a state hospital such as the Wisconsin General, most of the patients come from great distances, and for this reason an adequate follow-up is quite impossible. All of our patients are asked at the time of their discharge from the hospital to present themselves at the outpatient clinic for follow-up examination whenever they happen to be in the vicinity of Madison. By this means we are enabled to see a fair number of them some months after their discharge. No figures are available, but we are satisfied that on the whole the functional results of our prostatic surgery have been good. A few cases have been returned to the hospital because of unsatisfactory progress, but these cases are very few.

Carcinoma of the Prostate

The treatment of carcinoma of the prostate requires separate discussion, because in most cases it is purely palliative. The vast majority of these patients are seen after the growth has spread beyond the prostate, and, hence, after they are beyond any hope of radical curative measures. The general condition of these patients is usually poorer than those with benign hypertrophy. In most cases the transurethral resection of the obstructing tissue and castration is all that is attempted, and the result from a functional standpoint is often poor because of the nature of the tissue which is dealt with. Roentgen-ray treatment has been attempted with some of the younger individuals, but there has been little benefit from this form of therapy. Roentgen-ray therapy of bone metastases for the control of pain has been used quite frequently with fair results. During the last six or eight months of the period involved in this report, we were doing bilateral orchectomy in many cases, particularly those with painful bone metastases. In all patients with carcinoma of the prostate, we now perform the operation if radical perineal prostatectomy is not done. In other words, if we do not hope for permanent cure of the carcinoma, castration is done. In each of these, the operation has resulted in vast subjective improvement. The pain has disappeared, and the patients have been able to get along without morphine and, as a result, have regained an appetite and a sense of well-being and renewed hope. They have all been able to walk out of the hospital in vastly improved condition within a week or ten days after the operation, although some of them had been carried in on stretchers or wheel chairs suffering very great pain on the slightest movement. What the late results of this form of treatment will be we are unable to say, but certainly the immediate re-

sults are tremendously impressive. A few cases are seen each year sufficiently early in the course of the disease so that it seems to be confined to the prostate. In these cases, radical perineal prostatectomy is done in the hope of obtaining a permanent cure.

Eighty-seven patients with carcinoma of the prostate were seen in this hospital in 1940 and 1941. Fifty-eight of these cases were treated by transurethral resection with an operative mortality of 1.7 per cent, and four radical perineal prostatectomies were done with no deaths. Two patients had simple suprapubic cystotomies, and 1 of these died. Three deaths occurred in the remaining group of 22 patients who had no prostatic surgery.

The statistics as to length of hospitalization, amount of tissue removed, and amount of fever suffered are so similar to those figures given for the cases with benign prostatic hypertrophy that repetition is unnecessary.

The small number of radical prostatectomies reflects the common experience that carcinomas of the prostate are seldom seen in the early stages. There were only 4 in this group of 87 cases which were considered suitable for this operation. Routine careful rectal examinations of all men past the age of 50, with perineal biopsy of any suspicious lesion and radical operation where possible, may some day reduce the appalling mortality of this disease.

A brief review of the fifteen deaths among these 421 cases of prostatic disease follows:

Benign Prostatic Hypertrophy

Surgical Deaths

1. Age 78. Small resection with good recovery. Fulguration of a large bladder carcinoma a week later was followed by severe infection, uremia, coma and death.

2. Age 82. Grade III cardiac damage. False passage in attempting to introduce resectoscope. Urinary extravasation. Massive pulmonary collapse. Death.

3. Age 81. Resection followed by increasing cardiac failure, rising nonprotein nitrogen, uremia, and death twenty-four days postoperatively.

4. Age 74. Patient with severe cardiac disease. Sudden death from cardiac disease during the first two minutes of resection.

5. Age 73. Hypertensive patient with cardiac disease with moderate failure and severe bronchial asthma. Died from severe procaine reaction following administration of spinal anesthetic.

6. Age 68. Hypertensive patient with cardiac disease, functional capacity grade III, chronically uremic. Complete retention and many vesical calculi. Suprapubic vesical lithotomy. Long, slow convalescence. Prostatic resection with death on the fourth postoperative day from bronchopneumonia and cardiac failure.

7. Age 76. Bilateral hip ankylosis. Suprapubic prostatectomy. Fatal pulmonary embolus on fifteenth postoperative day.

Nonsurgical Deaths

8. Age 72. Complete retention, severe arteriosclerotic heart disease, and congestive failure. Death from congestive heart failure after six days in hospital.

9. Age 70. Catheterization to determine residual at time of admission, followed by severe urosepsis, uremia, and terminal pneumonia.

10. Age 85. Admitted in coma with complete urinary retention. Died in five days without regaining consciousness.

Carcinoma of the Prostate

Surgical Deaths

11. Age 65. Admitted with bladder distended with blood. Suprapubic cystotomy. Anuria and death from uremia. Autopsy showed both ureters obstructed by extensive prostatic carcinoma.

12. Age 78. Adenocarcinoma of the prostate and transitional cell carcinoma of the bladder. Arteriosclerotic heart disease, marked anemia, and chronic uremia. Died of severe pyelonephritis following resection.

Nonsurgical Deaths

13. Age 73. Had had two previous resections for obstructing prostatic carcinoma. Admitted in anuria. Died of uremia. Autopsy showed bilateral ureteral obstruction from prostatic carcinoma with extensive metastases to periaortic nodes.

14. Age 60. Decompensated heart, numerous and widespread metastases. Pneumonia. Death from heart failure and pneumonia after eight days in the hospital.

15. Age 64. Complete retention, uremic coma with nonprotein nitrogen of 250 and carbon dioxide combining power of 5 volumes per cent. Died after four days in the hospital without regaining consciousness.

Summary

During 1940–41, 421 patients suffering primarily with prostatic disease were admitted to the Wisconsin General Hospital. Of these, 381 received surgical treatment with an operative mortality of 2.3 per cent.

Eighty-seven (20.6 per cent) of the 421 patients had carcinoma.

The average age of the patients with benign hypertrophy was 67.7 years. Of these, 316 were operated upon; 262 had transurethral resection, 44 had perineal enucleation, and 9 had suprapubic prostatectomy. The operative mortality for this group of 316 was 2.2 per cent.

The average age of the 87 patients with carcinoma was 69.7 years. Fifty-eight of these had transurethral resection (and castration in many instances) and 4 had radical perineal prostatectomy. The operative mortality was 1.7 per cent.

The Cesarean Section Problem in Wisconsin*

By ROLAND S. CRON, M. D.**
Milwaukee

WISCONSIN has a national reputation as a great dairy state, a land of lakes, an area of cities with many important industries, and the location of a metropolis made famous not only by its breweries but also by its cesarean section record. In that metropolis, the ratio of cesarean sections to total deliveries is higher than in any other comparable large city in America. Last year Keettel analyzed for this society the Wisconsin record covering the years 1934 through 1940.[1] He reported a 6 per cent increase in the incidence of deliveries for the state but a 65.8 per cent increase in cesarean sections. This is more than ten times as fast as the birth rate increased. Such an upswing might have been justified if there had been a corresponding fall in the maternal and infant mortality rates, but this was not true. Counties showing a high section incidence had both high and low maternal and infant mortality rates.

Why should Wisconsin have such a high rate? Does Milwaukee County for example, have twice as many women with contracted pelves as does the rest of the state? Why should one large institution be able to practice excellent obstetrics with a cesarean section incidence of only 1.5 per cent and the staff of a neighboring institution find it necessary to make 23 per cent of their deliveries by this radical method? The answer to both of these questions is that this dramatic and easy method of delivery has been popularized by the profession, while the art and skill of obstetrics have been forgotten or lost by many physicians. The old dictum of first giving Mother Nature a chance to produce her offspring in the old-fashioned way before interfering has been too often abandoned. It may appear easier for the patient, and it certainly is more convenient and much more remunerative for the doctor, to have the patient's abdomen opened and the baby extracted at an appointed hour than it is to undergo the trials and tribulations of a long labor.

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[1] Keettel, William C.: A Report on Cesarean Sections and Hospital Deliveries Occurring in Wisconsin—1934 to 1940, Inclusive, Wisconsin M. J. 41:302 (April) 1942.

* Presented before the One Hundred First Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1942.

** Clinical professor and director of the Department of Obstetrics and Gynecology, The Marquette University School of Medicine, Milwaukee.

High Incidence of Cesarean Section in Wisconsin

For some years a few Wisconsin obstetricians have realized that the incidence of cesarean sections was unusually high in this state, especially in Milwaukee County. A further analysis of Keettel's splendid report shows that 27.6 per cent of all deliveries occurred in Milwaukee County but that 50.5 per cent of all cesareans were done in this county. Here, sections were done twice as often as in any other place in the state. What was and is there to do about it? We decided first to put our own houses in order. Consequently, in two large private institutions a plan was adopted whereby every physician, whether staff or nonstaff member, contemplating the performance of a cesarean section was obligated to obtain a consultation from a member of the obstetric staff of that organization. The consultant's services were rendered without expense to the patient. A record of his findings was made and an impartial opinion given, even though it disagreed with the wishes of the attending physician.

The effect of this procedure has had a manifold influence upon all concerned. Certainly it has had a deterring effect upon the urgency for cesarean section previously exhibited by many accoucheurs. It has, on the other hand, made the conservative management of the patient in labor easier for both physician and family. The moral support given the physician and the assurance afforded the family have been most satisfying, while the results have been most gratifying.

Consultation Service a Success

The two institutions mentioned above will be designated as hospitals A and B. The results are indicated in Chart 1.

CHART 1.

	Before Consultation Service Was Adopted		After Consultation Service Was Adopted	
Hospital	A	B	A	B
Deliveries	546	1097	632	1409
Cesareans	93 (17.1%)	80 (7.3%)	64 (10.1%)	70 (4.97%)

A study of these figures shows a very amazing thing. Here we have two institutions caring for exactly the same type of patient, but in two successive years the incidence of cesarean section is at least twice as high in hospital A. The rate in hospital A had reached the high figure of 17.1 per cent, and hospital B, 7.3 per cent. In another large hospital the rate for three years was even higher; namely, 23 per cent. Rates as high as these are common in other Milwaukee maternity wards. This suggests that in all probability deliveries were made by cesarean section when they could have been made in a more conservative manner. What did consultation service accomplish? In both institutions it reduced the frequency of this radical procedure from 17.1 per cent in hospital A to 10.1 per cent, and from 7.3 per cent in hospital B to 4.97 per cent. Note, however, that in hospital A cesareans are still done twice as often. Are the consultants in hospital A liberal?

The argument might be advanced that the high incidence may be influenced by the number of repeat sections. This is shown in Chart 2.

CHART 2.

	Before Consultation		After Consultation	
Hospital	A	B	A	B
First sections	48 (54.6%)	50 (62.5%)	35 (54.7%)	38 (54.3%)
Repeat sections	40 (45.4%)	30 (37.5%)	29 (45.3%)	32 (45.7%)

In both institutions the incidence of repeat sections was approximately the same. Actually, there were more of this type in hospital A. It is quite obvious that this has become the most common indication for this operation.

Infant Mortality From Cesarean Section

Does cesarean section necessarily assure the birth of a live or living baby, and can that be used as an excuse for performing the operation? Note that, as shown in Chart 3, there was a very high rate of stillbirths and of babies dying during the first ten days following their birth.

CHART 3.—MORTALITY.

	Before Consultation	After Consultation
	Hospital	Hospital
Infant	A. 4 died 4 stillborn 8.6% B. 2 died 2 stillborn 4.4%	A. 2 died 1 stillborn 4.7% B. 6 died 2 stillborn 11.4%
	Total: 14 dead and 9 stillborn babies in 307 sections; 7.5%	
Maternal	1 death .3%	

There were nine stillbirths and fourteen other babies that died during this period. This gives the very high infant mortality rate of 7.5 per cent for a little over 300 cesarean section births. Of course, some of these infants were lost due to the complication of abruptio placentae and placenta previa. However, full term infants occasionally fail to breathe following an abdominal delivery. The absence of the mechanism of labor, which plays a big part in the initiation of the respiratory effort, is absent in this mode of delivery. At times the resuscitation of the newborn infant calls for the need of one trained in the use of the tracheal catheter. Every maternity and operating room should be equipped with one of these instruments, and the resident surgeon should be experienced in its use. There is no method superior to this one for resuscitation of the asphyxiated newborn infant.

As for the chances of the mother's surviving this procedure, Keettel has shown that ten times more women die from delivery by cesarean section than from any other method of delivery. Many mothers are made invalids by this operation, and a goodly number require subsequent surgery. These later operations are also associated with an appreciable morbidity and mortality.

Types of Cesarean Sections

Any obstetrician or surgeon attempting to perform a cesarean section should be qualified and capable of performing any one of the three common types of sections. These are the classic, the low cervical or laparotrachelotomy, and the radical or Porro operation. Keettel's report showed a very high incidence of classic operations but only 13 per cent of the low cervical type. The Porro operation was done only seven times. In contrast to this state record, note the report from the two private maternity hospitals as shown in Chart 4.

CHART 4.

Types of Sections	Before consultation service		After consultation		
Hospital:	A	B	A	B	
Low cervical	88	72	64	55	90%
Classic	3	5	0	4	4.2%
Porro	2	0	0	2	1.3%
Not stated	----------	3	----------	9	----------

More than 90 per cent of the operations were of the low cervical type. There were only a few Porros. There was one death from sepsis following one of the few classic operations. Personally, I have not subjected a single pregnant mother to the classic type during the last ten years. After one has utilized the low cervical operation and found how easy it is to perform, how much greater is the comfort, and how much more rapid and successful is the recovery of the patient, one will relegate the higher and much more risky operation to the bygone ages. However, do not get the idea that this low operation is a panacea for the care of the grossly infected and neglected patient. The incision, located as it is under the bladder and in the pelvis, tolerates potential infection more successfully. Better drainage and more satisfactory wound healing likewise occur in this location. The radical or Porro operation should be used more often. It is the operation of choice when the uterus is grossly infected, lacerated, and ruptured, extensively myomatous or noncontractile due to extensive blood cell infiltration such as we very occasionally see in abruptio placentae.

Indications and Contraindications for the Operation

Cesarean section is rapidly becoming public enemy number one for the pregnant mother. It is one of the most common causes of death. Primarily, this is due to the failure of the operators to observe the indications and contraindications for the operation. Since cesarean section has become so popular, it was natural that the most common indication for the operation should be a subsequent pregnancy. In most instances, the old dictum of "once a cesarean always a cesarean" should continue to be the rule.

This rule may be modified in the case of the patient who has experienced an uncomplicated afebrile convalescence for nondisproportion and who goes into labor with a normal presentation, cervical effacement, and beginning dilatation. Labor should then be carefully observed and the accoucheur prepared to intervene surgically if the indication arises.

The obstetric patient who presents the problem of disproportion may be one of the simplest or one of the most difficult to handle. Naturally, the proposition of frank disproportions can and should be settled by elective cesarean section. It is the borderline case, however, that calls for the exercising of judgment and patience. Here is where experience counts and where the so-called test of labor should be practiced. The meaning of the term is an intangible one. It may consist in a six to eight hour labor of long and strong pains or one of many more hours of much less efficient contractions. If more pregnant mothers were given a fair test of labor, I am certain that there would be fewer sections and just as many live babies. All patients who eventually come to laparotomy following a test of labor should have the low cervical operation performed.

Cesarean section for the delivery of the elderly primipara has been a much overworked indication. The vast majority of these mothers will, if properly sedated, dilate the cervix and force the presenting part low enough into the pelvis so that vaginal delivery is possible. Cesarean section in order to sterilize the mothers by resection of the fallopian tubes is never justifiable. It is much safer to perform a laparatomy within the twenty-four hour period following delivery.

Toxemia of pregnancy is primarily a medical problem. The pre-eclamptic and eclamptic patient should be treated conservatively. Every effort should be made to obtain a vaginal delivery. Cesarean section is not the method of choice. It should never be used when the patient is in extremis, for it is then that it may be the straw that breaks the camel's back. Never is it justifiable to perform the operation in the presence of a dead baby except in the rare case of severe hemorrhage from abruptio placentae. Monsters, and especially the hydrocephalic baby, do not justify subjecting the mother to the risk of this operation.

The patient who has experienced a long labor with ruptured membranes, vaginal examinations, or attempted delivery is always a bad risk for this operation. Usually the vagina and uterus in these patients are infected. If there is no other feasible mode of delivery, the radical, or Porro operation is the most conservative procedure. Of course, this means the loss of childbearing, but at least the mother's future chances of caring for her baby are greatly increased.

Factors in Safer Performance of the Cesarean Section

It has been our experience that the regular and frequent instillation of a vaginal antiseptic, such as acriflavine or mercurochrome, into the vagina during labor adds to the safety of the operation. When the progress of labor is such that cesarean section is anticipated, 1 ounce of 5 per cent mercurochrome is injected into the vagina every four hours with an aseptic bulb syringe. This procedure is routinely practiced before all such operations.

The sulfonamides may be placed in the potentially infected uterine cavity and wound. However, one should not expect them to prevent the development of a septicemia or peritonitis in the frankly infected uterus. That uterus should never be incised. Instead some other mode of delivery should be utilized.

Delivery of the incised uterus outside of the peritoneal cavity is unnecessary and ill advised. The less the organ is handled, the better. The mopping of blood from the peritoneal cavity is one of those old habits which does more harm than good. Blood is readily absorbed. Trauma from sponging and the chance of introducing infection may be avoided.

Uterine bleeding is controlled by the injection of pituitary extract into uterine muscle and of ergotrate intravenously as soon as the head of the baby has been delivered. The purification of ergot and its present use in obstetrics have been two of the greatest advances in the field of obstetrics.

Since the introduction of intravenous anesthesia, we have found that local infiltration of the anterior abdominal wall and bladder flap followed by intravenous pentothal upon incising the uterus has been ideal. We realize that this necessitates team work and that it may not be suitable for all operators. However, when local anesthesia can be used and a minimum amount of anesthesia inhaled, much less difficulty is experienced with fetal resuscitation. This is the ideal procedure for the patient with cardiac or pulmonary pathology. Preoperative sedation with opiates has been abandoned. Instead, morphine or pantopon are administered intravenously, immediately following the clamping of the umbilical cord.

Summary

1. Wisconsin and, especially, Milwaukee County have experienced a very high incidence of cesarean section. In Milwaukee, the incidence in hospitals has varied from a low of 1.5 per cent to a high of 23 per cent per annum. These extremes are ridiculous and indicate that on the one hand too few may have been done, while on the other hand many were done needlessly.

2. Enforced conscientious consultation has materially reduced the incidence of cesarean sections in two maternity hospitals. This practice should be made compulsory by the staff of every hospital. Consultation service has been a success from the standpoint of both the accoucheur and the patient.

3. An equalization of the fee charged for vaginal and abdominal delivery might assist in an appreciable reduction of the high rate of sections. The customary remuneration in both instances is out of proportion to the services rendered.

4. The classic type of operation has been done much too frequently. For it, the low cervical should be substituted. Its performance is not difficult to master. It pays big dividends. The Porro operation should have been used more often. Many patients who died from a classic operation should have been delivered by some other method or at least been subjected to the radical operation.

5. Cesarean section does not necessarily result in the birth of a live or living baby. Twenty-three (7.5 per cent) of the 307 babies delivered by this method were dead or died within ten days following delivery.

6. Repeat sections in many institutions have become the most common indication for the operation.

7. The introduction of antiseptics into the vagina during labor, the insufflation of sulfonamides into uterine cavity and incision, the combining of local infiltration and intravenous pentothal anesthesia, and the intravenous administration of ergotrate and opiates have added greatly to the safer performance of the cesarean operation.

8. This is one of the rooms in the house of the medical profession that needs cleaning. Let us do it before someone else attempts to do it for us.

BOOKS AND PERIODICAL LITERATURE ON INDUSTRIAL HEALTH AVAILABLE AT MEDICAL LIBRARY SERVICE

The Medical Library Service has prepared a compilation of the reference material on industrial health which is available to members of the Society upon request.

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The Clinical Applications and Complications of the Sulfonamides*

By WESLEY W. SPINK, M. D.
Minneapolis

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AMERICAN clinicians have now had approximately five years in which to evaluate sulfonamide therapy. The advancements have been rapid. The entrance of our nation into an armed conflict has given further impetus to this type of therapy. Believing this to be an appropriate time to review briefly the present status of sulfonamide therapy, I shall present the principles underlying successful sulfonamide therapy, the compounds now available and the indications for their use, and the complications rising from the administration of these drugs. The statements that I shall make are based largely on the experience that my associates and I have had at the University of Minnesota Hospitals. Observations have been carried out on approximately 2,000 patients.

Principles of Therapy

Since the sulfonamide compounds act directly upon micro-organisms and thereby slow down the rate of reproduction, it is necessary that sufficient amounts of drugs should come in direct contact with bacteria in the tissues and body fluids. To reach adequate concentrations, it is now a general policy to administer a large initial dose of the selected drug and then to maintain the desired concentrations with frequent smaller doses. The question is often asked, "How necessary is it to determine blood sulfonamide concentrations?" In the severely ill patient with a systemic infection, and particularly when a compound is being given parenterally, it is our practice to ascertain the blood level in the early stages of treatment at least once every twenty-hour hours.

Experience has taught us that the best therapeutic results will be obtained in those patients in whom the most efficient drug is used on the basis of precise bacteriologic data. When a physician does not have the advantage of securing bacteriologic help, and he is certain that an infection is present, he should elect to administer a compound having a wide range of antibacterial activity. Under these circumstances we prefer to use sulfathiazole, except in patients with meningitis, in which instance sulfadiazine, or possibly sulfapyridine, is indicated.

Methods of Administration

The drugs should be prescribed for oral ingestion whenever practical. Sulfanilamide prepared as an 0.8 per cent concentration in physiologic sodium chloride solution may be introduced subcutaneously or as a continuous intravenous drip. The sodium salts of sulfapyridine, sulfathiazole, and sulfadiazine may be given intravenously in concentrations up to 5 per cent in saline solution or sterile distilled water. I emphasize the practicability of administering the sodium salts of the sulfonamide compounds subcutaneously, provided one does not use a concentration greater than 1 per cent in saline solution of sodium sulfapyridine or sodium sulfathiazole. Sodium sulfadiazine in concentra-

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tions up to 3 per cent in physiologic saline solution may be administered subcutaneously. Many preparations of the compound have been applied directly to the tissues. The advantage of such a procedure is that comparatively high concentrations of the drugs are obtained in the local areas. At the University Hospitals we do not utilize the sodium sulfonamide salts for local application because of the danger of tissue irritation resulting from the highly alkaline solutions.

Chemotherapy

The primary indication for administering one of the sulfonamide compounds is for the treatment of established infections. Nevertheless, more and more attention is being given to the prophylactic value of these drugs. Chemoprophylaxis is assuming a more important position in these times of war, both in the civilian population and in the armed forces. It has been observed that the administration of some of the drugs to carriers of meningococci is followed by a disappearance of the cocci from the nasopharynx. Therefore, if an epidemic of meningococcal meningitis should occur in either the civilian population or the armed forces, chemotherapy might be very valuable for the erradication of organisms in carriers, for the protection of exposed groups, and for the treatment of the disease. Likewise, epidemic influenza might strike suddenly and bring with it a high incidence of secondary bacterial, pulmonary complications. While the sulfonamides have no effect upon the virus of influenza, the drugs will offer a specific form of treatment for and, possibly, protection against streptococcal, staphylococcal, and pneumococcal pneumonia. During World War I, several epidemics of measles occurred in army cantonments in this country, and a frightful loss of life took place because of secondary streptococcal infections. Under the present situation, such a repetition might very likely be prevented by the prompt use of the sulfonamides.

The prophylactic value of the local implantation of the sulfonamides in accidental wounds and burns must receive further clinical evaluation. Gas bacillus gangrene has been one of the most horrible and highly fatal infections in the history of warfare. There is considerable experimental evidence showing that the prompt application of the sulfonamides, especially sulfathiazole, to contaminated wounds will prevent the development of gas gangrene. In World War I, it was found that 80 per cent of the deaths occurring in wounded soldiers because of infections were due to hemolytic streptococci invading the tissues. Paradoxically enough, streptococci entered the wounds after the individuals were placed in base hospitals. The medical personnel of the present conflict is cognizant of this feature of wound therapy, and such a sequence of events is less likely to occur.

Drugs Available and the Indications for Their Use

At this time, I shall present briefly the present status of drugs now available for general use. While many chemically related compounds have been investigated clinically, I am not presenting a discussion of their therapeutic virtues at this time. There are two compounds not available for general distribution. Promin is a compound that has excited considerable interest because its administration will control experimentally induced tuberculosis in the lower animals. As far as I know, there is no clear-cut evidence that the drug is effective in human tuberculosis. Sulfapyrizine is another compound that has been successfully used for the treatment of a small group of human patients with pneumococcal pneumonia. The clinical indications for the available compounds are as follows:

Neoprontosil

Neoprontosil was among the first compounds introduced into America for general clinical use. It proved to be an efficient compound. However, more effective sulfonamide drugs are now at hand. I see little need for using this compound today and have not prescribed it to a single patient during the last two years.

Sulfanilamide

Sulfanilamide has enjoyed the greatest popularity among American physicians and rightly so when one considers how its clini-

cal application revolutionized the treatment of many infectious diseases. It is interesting to review the progress of chemotherapy not only in our own hospital but also in other institutions throughout the country and to note the steady decline in the use of sulfanilamide for systemic infections. Sulfanilamide has proved to be extremely useful in the treatment of streptococcal, meningococcal, gonococcal, and urinary tract infections. Likewise, chancroid, lymphopathia venerea, influenza bacillus meningitis, and certain skin infections have yielded to sulfanilamide therapy. We have had satisfactory therapeutic results with sulfanilamide in the treatment of acute cases of undulant fever but not of chronic cases. There is little doubt that sulfanilamide therapy has resulted in improvement in selected cases of trachoma. We are now using other sulfonamide compounds for the therapy of practically all of the foregoing conditions. Sulfanilamide is being widely used in topical applications both for prophylactic and therapeutic purposes. We are becoming more and more impressed by the results that we are obtaining in peritonitis, particularly of appendical origin, following the local implantation of sulfanilamide crystals in the peritoneal cavity.

Sulfapyridine

The introduction of sulfapyridine into our chemotherapeutic armamentarium was followed by brilliant results in the treatment of pneumococcal pneumonia, gonorrhea, and certain types of bacterial meningitis. Sulfapyridine therapy is accompanied by disagreeable side effects well known to all of you; namely, nausea and vomiting. For this and other reasons, we are using very little sulfapyridine at the University Hospitals today.

Sulfathiazole

No sooner had sulfapyridine established its therapeutic reputation when sulfathiazole appeared on the scene. Today, sulfathiazole is being widely used at the University Hospitals and elsewhere for systemic infections. We consider sulfathiazole to be the drug of choice in the therapy of severe staphylococcal infections, gonorrhea, and urinary tract infections. Some authorities give first place to this compound in the therapy of chancroid, lymphopathia venerea, tularemia, and anaerobic infections such as gas gangrene. It is claimed that sulfathiazole is effective in plague, and there is little doubt that cases of acute bacillary dysentery have been cured by its use. Like sulfanilamide, sulfathiazole is being utilized extensively for local application to tissues. In fact, at the University Hospitals we have used more sulfathiazole for this purpose than sulfanilamide. More recently, justifiable apprehension has been expressed because the local application of sulfathiazole has been accompanied in a few instances by severe local and generalized manifestations of drug sensitivity. Some surgeons, notably Dr. J. A. Key of St. Louis, have advocated 2 parts of sulfanilamide to 1 part of sulfathiazole for local use. Such a combination has some therapeutic advantage.

Sulfadiazine

It has been the constant hope of those interested in chemotherapy to find a compound that is highly antibacterial and, at the same time, one that provokes a minimum of toxic reactions. It appeared from the earlier clinical investigations with sulfadiazine that in its use fewer toxic reactions would be encountered and that the drug would be just as efficient as the other sulfonamide compounds, if not more so. Unfortunately, some of the high hopes that attended the introduction of sulfadiazine have been blasted. This compound does cause severe toxic manifestations but, in our experience, less often than do sulfanilamide, sulfapyridine, or sulfathiazole. At present, we elect sulfadiazine for the treatment of beta hemolytic streptococcal infections and meningococcal and pneumococcal infections. We have had encouraging results with sulfadiazine in acute undulant fever. We are now using sulfadiazine for the treatment of streptococcal, meningococcal, and pneumococcal meningitis and also meningitis due to the Haemophilus influenza bacillus. Because of the insolubility of sulfadiazine, we are not using it for local application. We believe that sulfathia-

zole is superior to sulfadiazine in the therapy of staphylococcal and urinary tract infections and gonorrhea.

Sulfacetamide

Sulfacetamide ("Sulamyd") is closely related to sulfanilamide and has been stated to be more effective than sulfanilamide in the treatment of urinary tract infections due to gram-negative bacilli, particularly those due to Escherichia Coli. Also it is said to be less toxic than sulfanilamide. We prefer to use sulfathiazole for the treatment of urinary tract infections, because this drug has a wider range of antibacterial activity. The busy practitioner does not always have the facilities or time to decide if a urinary tract infection is due to gram-negative bacilli, and for that reason it would be more advantageous for him and the patient to use sulfathiazole.

Sulfaguanidine

Because of the low solubility of sulfaguanidine and its tendency to remain in the intestinal tract, this compound has opened up a new era in the chemotherapy of bacillary dysentery. Sulfaguanidine is particularly valuable in the treatment of bacillary dysentery due to the Shigella group of organisms, but it is much less valuable for infections due to the Salmonella or paratyphoid species of bacteria. It is of no value for typhoid fever, and the results have been almost uniformly disappointing in the treatment of typhoid carriers.

Succinylsulfathiazole

Succinylsulfathiazole (Sulfasuxidine) possesses properties similar to sulfaguanidine and is used for the same purposes. It is claimed that succinylsulfathiazole therapy results in fewer toxic reactions than sulfaguanidine.

Toxic Reactions to Sulfonamide Therapy

Every physician who has had an extensive experience with sulfonamide therapy appreciates the toxic reactions that the drugs may cause. In view of the widespread use of the compounds, the number of disastrous results is relatively small. We have much to learn concerning the pathogenesis of these toxic reactions. It is probably unnecessary to state that no individual should take a sulfonamide compound unless it is prescribed by a physician, and that the physician in turn should be prepared to keep his patient under close observation. A problem assuming increasing importance is based upon the fact that more and more individuals are being rendered hypersensitive to the sulfonamide drugs. That is, the patients tolerate a course of chemotherapy with or without reactions. Then at some later time, a small initial dose of the same compound or a related compound may induce severe reactions, such as chills, fever, skin eruptions, nausea and vomiting, and collapse. For this reason, before initiating sulfonamide therapy, physicians should question every patient closely as to whether he has received a "sulfa" drug in the past and, if so, whether or not he had an untoward reaction. If the physician is in doubt as to whether the patient is sensitive to a given compound, a test dose of 0.5 grams may be given and then the patient observed for twelve hours. In several instances, I have seen such a dose precipitate violent reactions. Patients may be rendered sensitive to one of the sulfonamide compounds but not to other closely related sulfonamide drugs. I have seen a number of patients who could not tolerate sulfathiazole, but therapy with sulfadiazine caused no disturbance. Fortunately, many of the reactions from the sulfonamides are not on the basis of hypersensitivity. In some instances the hypersensitivity that does occur does not appear to reflect a permanent property of the tissues.

Drug Fever

I should like to dwell upon those reactions that are more severe and that should occasion the physician to discontinue chemotherapy or to proceed very cautiously. Usually, these manifestations do not appear until the patient has been under treatment for several days. One is more likely to run into trouble after the second week of therapy. One of the most commonly encountered and puzzling reactions is that of so-called drug fever. This may or may not be accompanied

by chills. It is very difficult at times to determine whether or not these manifestations are due to the drug or due to a recurrence or a progression of the infection. Usually drug fever occurs after the patient has manifested some clinical improvement. Whenever the physician is in doubt about the etiology of the fever, chemotherapy should be terminated. I have observed an attack of drug fever with chills to continue as long as five to six days after the last dose of sulfonamide compound. Rarely, drug fever may appear shortly after therapy has been discontinued. We have observed the greatest incidence of drug fever in association with sulfathiazole therapy.

Dermatitis

Another common reaction frequently associated with drug fever is dermatitis. These skin eruptions differ widely in their morphology. Most physicians are acquainted with the erythema nodular lesions caused by sulfathiazole. One of the more serious skin reactions is an exfoliative dermatitis. It is our practice to omit drug therapy with the first appearance of an eruption, though in a few instances we have continued treatment with sulfathiazole in the presence of a nodular lesion. At times, the physician may utilize a sulfonamide compound other than the offending drug without any further difficulty.

The effects of the sulfonamide compounds upon the hemopoietic system deserve attention. The more serious complications are acute hemolytic anemia, leukopenia, and granulopenia, and finally, agranulocytosis. Thrombocytopenic purpura has also been observed. It is our policy to discontinue therapy whenever the leukocyte level falls below 4,000 cells per cubic millimeter, though exceptions have arisen. This procedure appears sound, since we have not observed a single instance of fatal agranulocytosis at the University Hospitals. Chemotherapy is not contraindicated in a patient having a severe infection with leukopenia before treatment has started.

Kidney Complications

More and more attention is being given to the kidney complications produced by the sulfonamides. The most frequent offender in our experience has been sulfathiazole. Sulfapyridine is next in frequency. In recent months, several reports have described fatal kidney complications occurring as a result of therapy with sulfadiazine. Sulfanilamide rarely produces renal damage. The pathogenesis of the renal and urinary tract complications is of interest. In the majority of cases, it would appear that the causative factor is a mechanical obstruction of urinary flow induced by the precipitation of crystals in the renal tubules, renal pelves, ureters, or bladder. I am convinced that in some cases renal damage and failure may be due to a direct toxic effect upon the renal parenchyma. This may occur in the absence of an accompanying obstruction due to precipitated crystals. The manifestations of complications rising along the urinary tract are renal or ureteral colic, hematuria, oliguria, anuria, nitrogen retention, and uremia.

Can these kidney complications be prevented? There is evidence that the maintenance of an alkaline urine will lessen the tendency for crystals of sulfadiazine to precipitate along the urinary tract. This does not apply to sulfapyridine. It is necessary to give from 10 to 20 Gm. of sodium bicarbonate daily in order to maintain an alkaline urine. An important additional procedure is to watch the daily output of urine, which should exceed 1 liter per twenty-four hours. We believe that gross hematuria, renal or ureteral colic, and oliguria, which cannot be speedily corrected, are definite indications for discontinuing therapy. When anuria occurs, the patient should be cystoscoped, and ureteral catheters should be passed up to both renal pelves. The pelves should be irrigated frequently with a warm, alkaline solution. Rarely, brilliant results may follow such a procedure.

Conclusions

Many problems pertaining to sulfonamide therapy remain unsolved. There are a number of infections, particularly the virus diseases, which are unaffected by the sulfonamide compounds. Other compounds will be brought forth for clinical trial. In many

laboratories and clinics in this country today, investigations are going on in a search for more efficient antibacterial agents. Much of this work has been stimulated by the national emergency, and results at hand cannot and should not be disseminated. However, by the time the present chaos has died down, and we are secure to continue as a nation, tremendous advances in our attempts to control infections will have occurred.

The Modern Status of the Sulfamido Group of Drugs Used in Urology*

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T. L. POOL

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SINCE the ketogenic diet was introduced as an aid to the treatment of the patient suffering from urologic disease, great advances have been made in similar lines. It no longer is necessary to advise patients to keep the urine acid and to drink large amounts of water, because there are now available definite chemical substances which assist physicians in the care of such patients.

The discovery that mandelic acid could be used as an agent against infections of the urinary tract was another step forward. Since that discovery, sulfanilamide and its derivatives have been used as adjuncts to other forms of treatment.

The "Sulfa" Drugs Are Not Cure-Alls

The discovery that sulfanilamide and its derivatives were effective against certain forms of infection was a great advance, not only for urology but for medicine in general. However, it must always be remembered that these drugs are not cure-alls and that they should be used only when there are specific indications for them. The tendency at present is to use them as cure-alls. Eventually, this practice will lead to serious trouble. Recently I saw a patient whose condition illustrated this point. A male child, 15 months old, became anuric after the administration of sulfadiazine, with which he had been treated because of a slightly sore throat. Fortunately, the anuria responded to the usual measures.

The present trend is to prescribe one of these drugs and then allow the patient to observe himself for a given number of days. This trend also can lead to trouble, since the patients have no idea of the toxic reactions which the drugs can produce and will interpret them mistakenly. At the Mayo Clinic we feel that patients receiving any form of sulfanilamide should be observed at least every forty-eight hours. Most of our patients are seen every day.

In spite of the fact that these newer substances are now readily available, we still use some form of mandelic acid in many cases in which there is infected urine. In our hands, sulfanilamide and its derivatives have been of little value in sterilization of the urine when the infective agent is the Streptococcus faecalis. In coccal infection we must frequently use every means at our disposal to effect sterilization of the urine. In some cases, of course, the urine cannot be rendered sterile. Helmholz has shown that the Pseudomonas aeruginosa is particularly resistant to the sulfanilamide derivatives.

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Extensive Use of Sulfathiazole

For patients suffering with a urinary infection of a type for which a sulfanilamide derivative can be prescribed, we are now using sulfathiazole more than any other drug. We prefer to prescribe a relatively small dose, which usually is 15 grains (1 Gm.) taken three times per day. Administration of the drug is continued for seven to ten days, and if the urine is not sterile at the end of this time, either some other form of medication is prescribed or all medication is stopped for the time being. If the urine is sterile, experience has shown that it is advisable to continue the medication for three or four extra days. Occasionally, patients will state that they cannot tolerate this dose, and in such a case a smaller dose can be tried. Very infrequently, administration of even the smaller doses may have to be discontinued and some other drug substituted.

Daily Observation an Important Factor

It is felt that daily observation is one of the most important factors in the care of patients who are taking sulfanilamide or its derivatives. If the patients are seen regularly, early toxic reactions can be recognized and dangerous reactions can be avoided. In our experience at the clinic, such observation has been more important than the regular making of blood counts and estimations of the concentration of the drugs in the blood. This is particularly true in respect to patients treated by the Section on Urology, since all of them are receiving a relatively small dose of the appropriate drug.

Most authorities believe that estimations of the concentration of a sulfamido drug in the blood and in the urine should be made at regular intervals. Intelligent care of the patients does not make this practice necessary in every case. Occasionally, the procedures should be carried out, but regular observation of the patients and the estimation of the output of urine are of more importance. This is especially true when it is considered that usually there is little correlation between the concentration of the drug in the blood and the urine and the response the patient makes to the drug.

Toxic Reactions

The toxic reactions generally encountered among patients taking small doses of these drugs are not severe. Nausea, occasional vomiting, and giddiness are the ones usually noted. At times a rash may develop, or a febrile reaction may occur. Only very infrequently will leukopenia or a hemolytic type of anemia be encountered in the treatment of these patients. It might be well to state herein that none of the sulfamido derivatives is entirely blameless in the causation of these reactions. Sulfadiazine probably is tolerated as easily as, if not better than, any of them; yet it can cause any of the reactions which accompany the use of any of the other derivatives. Any of these drugs can form crystalline material in the collecting tubules of the kidneys, and there is some evidence to show that the acetylated form of sulfadiazine is more insoluble than products formed in the system by any of the other derivatives of sulfanilamide.

Perhaps a word should be said about the anuria which occasionally follows administration of the sulfamido drugs. The crystalline material is said to form in the collecting tubules, but the real obstruction, as noted clinically, is in the ureter. That this is true is seen in the fact that treatment consists of catheterization of the ureter and the institution of drainage from the pelvis of the kidney, and that when such drainage is obtained, blockage above this point will resolve without difficulty as a rule.

When a derivative of sulfanilamide is used as the chemotherapeutic agent in the treatment of uncomplicated infections of the urinary tract, what results can be expected? At the clinic, we feel that the percentage of cure should be approximately 90 in the common run of such infections. Various factors play roles in determining whether or not cure can be effected.

Factors Causing Therapeutic Failure

The factors which can cause a therapeutic failure are easily understood. In a few cases the drug cannot be tolerated, or a toxic manifestation occurs; in such instances it is necessary to discontinue administration

of the drug. Other factors which can cause failure are the presence of a tumor, a calculus, imperfect drainage of any part of the urinary tract, or marked involvement of the tissues with resulting cicatrization. Naturally, when any of these factors is present, a clinical miracle cannot be expected, nor can it be expected that an infected urine will become sterile. This fact has been expressed many times by Cook.

In cases in which there is longstanding, chronic infection, it occasionally becomes necessary to change the mode of administration of the drug. Frequently, the patient is asked to take the drug for the first week of each month under the supervision of a physician. At times it may be best to prescribe very small doses to be taken during a longer period. In prescribing the sulfamido derivatives in alternate courses, the physician should remember that toxic reactions are likely to occur if use of the drug is resumed within less than seven to ten days after it was discontinued. Why this is true cannot be readily explained. Perhaps it is best in some cases to alternate use of the drug with use of some other urinary antiseptic agent, such as mandelic acid.

Some of the greatest apprehensions confronting the physician caring for patients who have urinary infections have their source in the recurring bouts of acute infection which afflict certain of his patients. Usually, no focus of infection can be found, although among women the cervix frequently is suspected. When no focus of infection can be found, little can be done except to administer to these patients some form of alternate therapy in the hope that the attacks will become less frequent until they eventually disappear. Braasch has used this method for many years.

The Treatment of Gonorrhea

The treatment of gonorrhea at present seems to be rather confused. Perhaps the advent of sulfanilamide and its derivatives has caused more confusion than any other event in the history of the therapy of gonorrhea. None of the authorities agree on which particular drug is the one of choice, and no doubt it would be an opportune time now for someone to clarify the entire situation.

When the treatment of gonorrhea is discussed with many of the physicians in the armed forces, a great diversity of opinion arises concerning the most efficacious drug to prescribe. Many of these physicians feel that sulfadiazine is the most efficacious, while others feel that sulfathiazole is the drug of choice. For various reasons, at the clinic we are using sulfathiazole entirely.

In prescribing sulfathiazole in the treatment of gonorrhea, we prefer to begin, as in other instances, with a moderate dose of the drug. If this is well tolerated, the dose can be increased, should an increase become necessary. Our initial dose varies from 45 to 60 grains (3 to 4 Gm.) per day, administered in divided doses. The patients are instructed as to diet and general hygiene in exactly the same manner as were similar patients in the days before sulfanilamide was available. We feel that this is important, since sexual excitement, use of alcohol, and other factors, may in many cases, if not controlled, make the course of treatment much longer than necessary.

We still feel that local treatment in combination with chemotherapy has a place in the care of the patients suffering with gonorrhea. This is true if for no other reason than that it brings the patient back to his physician each day. In this way the general behavior of the patient can be more nearly controlled than would be possible otherwise. This local treatment should be started only after the acute stage of the disease has passed. It consists of the application of standard drugs to the mucous membrane of the urethra. Still later, gentle prostatic massage is begun.

Chemotherapy Plus Fever Therapy

At the clinic, in case the response of the patient's condition to the original drug is not what it should be, we usually resort to administration of one of the other derivatives of sulfanilamide to see what effect can be produced with it. At times we continue to administer the first drug used in an increased dose which sometimes is as high as 90 grains (5.8 Gm.) per day, administered

in divided doses. If this procedure is not successful in bringing the disease under control, we then must consider the use of chemotherapy plus fever therapy. We have seen no patient who could not be cured by such a course of therapy, although at times it has become necessary to repeat the long course of fever therapy once or even twice.

Sulfanilamide as a Prophylactic Agent

The use of sulfanilamide as a prophylactic agent is an interesting practice which is now being evaluated. Emmett has shown that if small doses of sulfanilamide derivatives are administered during the postoperative period, they help to reduce the incidence of infections of the urinary tract among women who have undergone gynecologic operations. Thompson and Strom recently studied the effects of sulfathiazole administered during the preoperative and postoperative periods to patients undergoing transurethral prostatic resection. They concluded that the morbidity rate was decreased and that the complications usually encountered after this type of operation were less frequent after such treatment. Perhaps this subject will be more thoroughly studied in the future.

A Plea to Physicians

In closing, I make the plea that physicians prescribing any of the sulfamido drugs attend their patients with the care that is given to the diabetic patient who is taking insulin. The sulfamido drugs now being used for the purpose of eradicating infection are not mild, and they may act as a two-edged sword.

A Roentgen Study of Virus Pneumonia*

By HOWARD P. DOUB, M. D.
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FOR several years, interest has been aroused by an atypical pneumonia which has sometimes appeared to occur in endemic form and for which no well defined etiologic agent can be ascribed. Reimann[1] believed it to be due to a virus; hence, the name virus pneumonia, which is now being used. It is now thought to be a distinct disease entity, often assuming the form of an acute tracheobronchopneumonia. In isolated cases the diagnosis may at first be obscure, but it becomes clear as the disease progresses through its various stages. In the endemic form it is more easily recognizable.

Early Roentgenologic Descriptions

One of the earliest descriptions of the roentgenologic aspects of this disease was by Bowen[2], who in 1935 described the lung changes which occurred as a complication of endemic influenza in Hawaii and suggested the term "acute influenza pneumonitis" as descriptive of the clinical pathology present in these cases. He showed that there were confluent areas of density presenting the appearance of exudative alveolar infiltration in various portions of the lungs, especially at the bases. The disease was usually of a mild character, and pneumococci were almost never found.

In 1938 Reimann[1] reported a series of eight rather severe cases of tracheobronchopneumonia. The clinical features were such as to suggest a different etiology than that of influenza or the usual form of the common cold, and Reimann was led to regard it as a separate disease entity. Recovery of a filtra-

* Presented before the One Hundred First Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1942.

ble virus in two cases suggested that this may have been the etiologic agent. The disease began with a mild sore throat, with a later development of high fever, cough, dyspnea, cyanosis, sweating, and drowsiness. Headache was present in all cases. In several patients, the symptoms were distinctly neurologic in character and suggested the presence of meningo-encephalitis. The fever lasted from ten to forty-three days, but the roentgenologic evidence of lung involvement persisted in some cases for weeks or months. The leucocyte count was low in proportion to the other clinical findings, and the blood cultures were negative.

Longcope[3] later described in detail a series of 32 cases of bronchopneumonia of unknown etiology which he designated "pneumonia variety X." Of the total number of patients, 18 were doctors, nurses, and other hospital personnel. Nine of the entire group were severely ill, and 2 died, both of whom had chronic rheumatic heart disease. Kneeland and Smetana[4] at about the same time reported 52 cases with one death. They believed that they were dealing with a new disease entity and stressed particularly its ease of transmission, which is confirmed by other writers and by our own series of cases.

In 1940 Kornblum and Reimann[5] reported the roentgen changes observed in an epidemic of acute respiratory infection. In a series of 407 cases, about 25 per cent required hospital care, and of these 86 were studied roentgenologically. Forty showed a negative roentgen picture, 24 had an acute tracheobronchitis, and 24 had an atypical pneumonia. In the negative cases and those with atypical pneumonia, there was close agreement between the roentgen and clinical findings, but in the group having acute tracheobronchitis there was opportunity for error. In the latter group, the hilar shadows were definitely large but not well defined, presenting a decidedly blurred appearance, and there was a soft mottling in the pulmonary tissues about the hilar area. There was also a generalized hazing throughout the lung field, giving the impression of an underexposed roentgenogram. The lateral view of the chest was valuable in the recognition of this condition.

Difficulties in Identification

One of the chief difficulties in establishing the identity of these atypical pneumonia cases has been the lack of demonstration of a causative organism and the inability to produce the disease in the usual laboratory animals. Many animals have been tried, and in several instances ferrets have appeared to be useful for this purpose. Weir and Horsfall[6] showed that the wild mongoose was susceptible to a virus isolated from throat washings obtained from patients with the disease. The virus was neutralized by the serum of animals convalescent from the disease. They felt that their evidence strongly suggested that this virus is the cause of acute pneumonitis in human beings.

Symptoms

The disease may occur at any time during the year but is more common during the fall and winter months. It is often ushered in with a few days of generalized malaise. The onset is insidious, and an unproductive cough is quite common. Headache of a severe character, as described by Reimann, is frequently present and is one of the prominent symptoms. The febrile reaction is insidious, but after four or five days the temperature varies from 100 F. to 105 F. In many instances the pulse rate and respiration are not proportionately elevated. At this stage of the disease the physical examination is usually negative or may disclose only slight suppression of the breath sounds and a few fine râles. The roentgenologic changes at this time are often quite well marked.

As the disease progresses, the physical signs become more prominent, with impairment of percussion and suppression of the breath sounds. These findings tend to persist for a considerable period even after cessation of symptoms. There is a rapid development of symptoms followed by a slow recrudescence in the more serious cases. The temperature shows a wide range of rise and fall without regularity. It usually approaches the normal figure at some time during the twenty-four hour period.

The white blood count, as a rule, is relatively low. In many cases in our series, it was between 6,000 and 8,000. The sputum

examination rarely reveals pneumococci, and usually no significant organisms are found. Blood cultures were never positive in our cases.

Roentgen Changes in the Lung

The roentgen changes in the lung vary according to the type and stage of the disease. In some cases the hilar areas are extensively involved, with radial bronchovascular markings extending out toward the periphery accompanied by a generalized hazing of the lung field. The more common and more characteristic lesion is manifested by areas of increased density in various parts of the lung parenchyma. In mild cases these areas are single and of limited extent and degree, while in more severe cases they occupy a considerable portion of the lung. The density is sometimes uniform, suggesting areas of lobar pneumonia, but usually striation can be seen through it, and the margins are not well defined. In other cases there occurs a widespread coarse miliary type of infiltration without localizing signs.

These dense areas are observed to react in various ways. In some instances they clear rapidly and completely, with rapid recovery of the patient. In others the lesion tends to migrate to other portions of the same lung with clearing of the original area while the new one continues to spread.

In almost half of the cases in our series the opposite lung became involved. Lesions were sometimes clearing in one lung while developing in the opposite lung. One of the unusual and baffling aspects of the disease occurred in those cases with apical involvement. In such cases it was frequently impossible to differentiate the lesion from tuberculous infiltration at the time of the initial roentgen examination. It was only by the subsequent clinical course and progress roentgen studies that the true nature of the condition was recognized. In many instances the roentgen examination disclosed evidence of the disease several days before the physical signs were positive.

Resolution

Resolution in some cases occurred rapidly with a progressive loss of density, so that in a few days little evidence of the lesion remained. In the mild cases this varied from three to twenty-one days with an average of nine days. In other cases the uniform density tended to clear, but an irregular area of fibrotic-like infiltration remained for a considerable period, even after all of the symptoms had disappeared and the patient believed himself well. In the moderate cases the average clearing time was seventeen and three-tenths days and in the severe cases forty-seven days, with a lower limit of fifteen days and an upper limit of ninety days.

Case Reports

Case I. A white man, age 24.

Complaint: Chills with fever, headache, and cough during the twenty-four hours preceding admission.

Physical Examination: The throat was injected. There were fine moist râles at the right base and moderate suppression of the breath sounds.

Laboratory Findings: W. B. C. 7,500. Blood cultures negative.

Roentgen-ray Examination: Chest clear the first day. On the sixth day there was evidence of pneumonia at the right base (fig. 1). On the fourteenth day the chest was clear (fig. 2).

Progress: Temperature 102 F. This declined to normal in thirteen days. All symptoms cleared gradually. Râles persisted for sixteen days. Discharged as well on twenty-first day.

Fig. 1.

Fig. 2.

Case II. A white woman, age 13.

Complaint: General malaise with cough, headache and fever.

Fig. 3.

Physical Examination: The chest was negative except for a few râles over the right upper.

Laboratory Findings: W. B. C. 7,300. Blood cultures negative. Sputum negative.

Roentgen-ray Examination: Parenchymatous infiltration in right upper suggesting tuberculosis (fig. 3).

Progress: Temperature 102.4 F. This declined irregularly to normal on the tenth day of illness. Roentgen-ray on sixteenth day showed lungs to be clear (fig. 4).

Fig. 4.

Case III. A white woman, age 21.

Complaint: For the past week, pain in the chest, cough, purulent sputum, and fever. Severe headache now.

Physical Examination: Pharynx red. Relative impairment of percussion over left base. Râles over both bases.

Laboratory Findings: W. B. C. 6,750. Blood culture negative. Streptococci predominate in the sputum.

Roentgen-ray Examination: Partial consolidation in both bases, not of uniform density but patchy in appearance (fig. 5).

Progress: Temperature 103 F. down to normal on the sixth day. Roentgen-ray changes clearing very well on twelfth day (fig. 6). Patient was seen in the outpatient department on the twenty-second day. She was much improved but still weak. The chest was clear at that time.

Fig. 5.

Fig. 6.

Discussion

It is the studied opinion of most writers on this subject that we are dealing with a distinct disease entity. The onset is insidious and is characterized by headache, cough, chilliness rather than true chills, and sometimes chest pain. The sputum is scanty and contains no pneumococci. The physical findings are slow in developing and are never characteristic as in lobar pneumonia. The temperature shows a sharply fluctuating course from 100 F. to 105 F. and falls by lysis. There is usually a wide disproportion between the temperature and pulse rate.

The roentgen changes are the earliest physical signs present and vary from hilar enlargement with hazing and blurring of the bronchovascular markings to areas of partial consolidation. In some of our cases there was a coarse miliary type of infiltration. Cases with apical involvement simulated tuberculous infiltration and were difficult to differentiate at the time of the first observation. The areas of involvement tended to migrate in the same lung and to spread to the opposite lung in about half of the cases.

The disease appears highly transmissible, and the incidence among hospital personnel and other groups is high. The incubation period is from two to three weeks with an average in our series of eighteen and seven-tenths days. The exact etiology is not known. Some investigators have isolated a virus which has produced the disease in the mongoose, although it is difficult to effect a take in the ordinary laboratory animals. There is no specific therapy. Treatment is largely symptomatic. The sulfonamide drugs are usually not effective. The mortality is low. In our series of 125 cases, there has been no death to date.

BIBLIOGRAPHY

1. Reimann, H. A.: An Acute Infection of the Respiratory Tract with Atypical Pneumonia, J. A. M. A. 111:2377 (Dec. 24) 1938.
2. Bowen, A.: Acute Influenza Pneumonitis, Am. J. Roentgenol. 34:168 (Aug.) 1935.
3. Longcope, W. T.: Bronchopneumonia of Unknown Etiology (Variety X), Bull. Johns Hopkins Hosp. 67:268 (Oct.) 1940.

4. Kneeland, Y., Jr., and Smetana, H. F.: Current Bronchopneumonia of Unusual Character and Undetermined Etiology, Bull. Johns Hopkins Hosp. 67:229 (Oct.) 1940.
5. Kornblum, K., and Reimann, H. A.: The Roentgenological Aspects of an Epidemic of Acute Respiratory Tract Infection, Am. J. Roentgenol. 44:333 (Sept.) 1940.
6. Weir, J. M., and Horsfall, F. L., Jr.: The Recovery from Patients with Acute Pneumonitis of a Virus Causing Pneumonia in the Mongoose, J. Exper. Med. 72:595 (Nov.) 1940.

The Present-Day Treatment of Varicose Veins*

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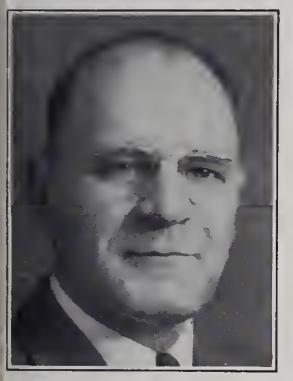

H. O. McPHEETERS

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THERE have been few new developments in the treatment of varicose veins within the last few years. Rather, it has been a case of proving the correctness of the theories underlying the treatments and a perfecting of the technics used.

Sclerosing Solutions

The ideal sclerosing solution has not yet been found. An occasional patient will be found here and there who is allergic to any of the solutions which we have at present other than the plain sugar and sodium chloride combination. Though these latter do not cause allergic reactions, they are a most potent cause of sloughs if injected outside the vein. No solution should be used in a very strong concentration. It is far better to use a weaker solution and to have to reinject the varix than to use the concentrated solution and have a violent reaction which is very painful, often disabling, and the cause of definite needless damage and injury to the lymphatics of the area similar to a severe burn and, moreover, even the source of a true necrotic slough at times.

The 2 per cent and 5 per cent solutions are the ones most commonly used. Sodium morrhuate (5 per cent) is probably used more than any other solution, although sylnasol, soricin, quinine, and potassium oleate are used and preferred by many. For the bursts, I prefer a 0.5 per cent or a 1 per cent solution and an entirely different technic than for the large varices.

Much time can be saved and better work can be done if the varicose system is well studied before the treatment is started. The patient should stand with the leg relaxed while it is being examined. The exact varices to be injected should be selected and then marked with some solution so that they can be quickly seen and injected when the varicose veins are only partly full. Without this preliminary marking, important segments may be missed or at least poorly injected. It is a definite aid in this technic.

The Empty Vein Technic

The development of the proper technic of giving the injections is very important. The theory of the empty vein technic is correct and should be followed as accurately as possible. It is up to each individual operator as to how he can best accomplish this. In other words, he must work out the details for himself.

The principle of the empty vein technic is the same as has been advocated for years. It should be our purpose to introduce the sclerosing solution into the lumen of the vein in a known concentration. Thus, if we wish to use a 1 per cent, a 3 per cent, or a 5 per cent solution, we should strive to keep it un-

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diluted with a large amount of blood and inject more or less as desired to sclerose the individual segment being treated. This can be done only by introducing the needle on the loaded syringe into the lumen of the distended vein, draining the vein, and then injecting the sclerosing solution into the empty and collapsed vein. With a little experience and effort, this technic can be mastered and perfected, and the results of the injections can be improved accordingly. The injection of a stronger solution into a large and distended varix with the hope that a sufficient sclerosing effect may be produced is not good reasoning, even though it does often so happen and develop. If a large amount is used and the varices are already filled, it cannot be retained locally but will spread through the communicating veins and cause damage to the veins of the deep system. This is much less liable to happen with the empty vein technic, since the varices are at no time more than partly filled as the solution is injected, and with the use of tourniquets it can be retained locally with a considerable amount of accuracy. With this technic a swollen leg seldom results from the treatments, while otherwise it occurs often. Many good and experienced men do not use the tourniquets, but I believe they help much to keep the solution under control. To those who doubt the efficiency of the tourniquet I simply say, "Inject a typical case with the above technic under the fluoroscope using some opaque solution such as skioden and see how well it can be retained as desired."

Necessary Precautions

Much care should be used to avoid extra perforations of the vein wall. I am sure that many severe reactions develop as the result of the sclerosing solution oozing out into the perivascular tissues through the extra perforations in the vein wall after the solution has been injected into the full vein. I try to follow the principle that if the vein is distended before I can inject the solution or if I have carelessly made extra punctures through the wall, then it is best not to inject into that segment at that time.

The importance of sharp needles cannot be overemphasized, for nothing makes the injections go more smoothly. Dull needles will spoil an otherwise perfect technic.

Too much emphasis cannot be placed on the supportive strapping of the varicosities after the injections have been made. A small one-quarter inch thrombus will organize in a much higher percentage of cases than will a large one inch thrombus. The latter will liquify in the center and recanalize. For this reason the large varices are always strapped as the treatment is finished to hold them small while they thrombose during the twenty-four hours after injection. If this reaction is severe, then the support must be continued for several days with adhesive strapping or a four inch elastic bandage. On the thigh, the elastic adhesive is best for this purpose.

The above technic is that employed for the treatment of the mild to moderate case of varicose veins. There is much difference of opinion, and rightly so, as to how to care for the extensive case with a marked reverse flow or positive Trendelenberg test. Some surgeons argue that any case of varicose veins that is bad enough to inject should have a *high* ligation at the junction of the saphenous vein and the femoral vein. Others use the ligation for only certain cases and have definite indications for its use. I belong to this latter group. If the veins are 1 or 2 cm. in diameter in some places but lie close under the skin, they can be easily, repeatedly, and successfully injected. If they are deep through the thigh, then they cannot be. If the veins through the thigh and lower leg are only 1.5 or 2 cm. in size but the junction at the femoral vein is a large funnel mouth opening 3 to 4 cm. in size, then it is foolish only to inject, as the pressure will be transmitted from the deep femoral vein outward through this funnel, and the thrombus will recanalize in a large percentage of the cases during the next six months. Even though the saphenous vein is well sclerosed, this pressure will dilate the branches and cause new varicosities. This case must have a preliminary ligation. If the vein has been treated and repeatedly injected over a period of years or the patient

has had many mild attacks of phlebitis, then we will find the valves gone and the vein a mere tube. The saphenous vein responds poorly to the injections and should be ligated even though it may not be large.

In the treatment of the borderline case, good results may be obtained by the injections alone, but there is a high probability that the condition will recur. I prefer to ligate this first. When the patient comes from a distance, excellent results at all odds are required, for there will be no chance for the usual careful and prolonged follow-up care. One must ligate as a double assurance of a good final result.

"High Ligation"

By the term "high ligation," I mean exactly that—a ligation of the great saphenous vein actually at its junction with the femoral vein and not two to three inches below. Often two or three branches will be found entering the saphenous vein in the first one inch below the femoral vein. A ligation two inches below will miss all these, and the recurrences in many cases that have been ligated are due solely to new varicose vein formation through these branches and with an extension down the thigh. A high ligation is truly a hospital procedure just as much as is a femoral hernia, for the dissection is carried to almost the same point.

The ligation will be made much easier if the exact line of the great saphenous vein at the groin is located by means of the Schwartz or percussion pulse test with the patient standing. This is simple and easy and takes but a minute. A mark is made with a 5 per cent alcoholic solution of gentian violet or brilliant green along the vein, and a second, one finger breadth below and parallel to the groin. The latter is the line of the incision. This will place the incision below the maceration and infection so often seen in obese women. The ligations must be done under local anesthesia because the patient must be ambulatory immediately afterward.

Control of Reaction

Some surgeons advise preliminary ligation, while some inject and then ligate. Others inject the sclerosing solution at the same time. I prefer the latter method. The amount of the solution injected must vary with the size of the veins and depending upon whether only one or both sides are ligated at the same time. The extent of the reaction must be controlled. It must be kept in mind that the patient receiving this treatment must at all times be kept ambulatory. One must consider the soreness of the incisions and not add so much to this with the sclerosing phlebitis that the patient will be unable to be up and about. Thus, we can have equal reactions in both thighs or much in one and little in the other. The technic of the injections with the operation also varies. Most operators simply inject the solution distally, ligate the vein, and make no attempt to empty the full and distended varicosed vein into the deep system. There is no other place for it to go. This is not the desired result. The technic with the urethral catheter is theoretically ideal but practically not so. If the varicosed saphenous vein is very tortuous, as it usually is, then it is almost impossible to work the catheter down the vein to the ankle. If it is not tortuous but rather tubelike, then another method is far superior. This method I have developed over a period of years with careful roentgen-ray check to prove that I was right.

I insist that the patients rapidly walk the equivalent of one block immediately after they leave the operating table and before they dress, and then they must walk for five minutes out of every hour for the next ten hours. This precludes the possibility of having a stagnation thrombus develop. I simply do not worry about it at all. If the ligation is done under a general anesthesia, then we must except a simple stagnation thrombus and a red blood clot in the veins below, and we are simply asking for an embolus to develop. A check of most of the emboli in these reported cases shows that these patients were given a general anesthesia. In my total 1,174 ligations, I have had only one fatal embolus. This was due to a technical fault of mine and should not have happened, and it will not happen again.

Preoperative Marking

With the aid of the preoperative marking, the vein is easily located, and the dissection is made much more easily if the sheath of the vein is carefully peeled off. The vein is then clamped and sectioned, leaving a stump of one-half inch on the distal segment to grasp later on. The proximal stump is then dissected upward to the foramen and the femoral vein. This is easily recognized by the small external pudendal artery which is very constant. It usually lies just below the foramen. There are usually three or four branches to ligate, and then the main proximal stump is ligated in the foramen. In this way there are no branches left through which we may get a recurrence, and there is no proximal stump left in which a thrombus can form to cause an embolus later. The proximal stump should be double ligated; personally, I put a purse string suture about the opening to reinforce the ligature on the proximal stump, on the assumption that we have a weakness of the fascia lata at that point. The soft flexible cannula on a syringe containing the sclerosing solution is then slipped downward into the distal stump, and a ligature is drawn tightly about it. The patient is then tipped into a marked Trendelenburg position, and the leg being treated is raised high. In this way the blood will drain out of the varicose system through the communicating veins into the deep femoral vein and the abdomen. After the patient has been in this position for one minute, the table is tipped into a marked reverse Trendelenburg position, and the leg is then quickly dropped to the table. As the leg is dropped, the solution is injected, and gravity will carry it down into the now empty varicose veins. Usually 4 to 5 cc. of 5 per cent sodium morrhuate will be used. After 3 cc. of this has been injected, I wait one minute and then inject the rest. This will distribute the solution throughout the varicosed veins. Often it will be carried even to the ankle and much more simply than with the catheter method.

The distal stump is ligated as the cannula is removed, and the wound is washed out with normal saline on the assumption that some of the sodium morrhuate may have spilled into the wound. The wound is closed as usual.

Careful Follow-Up Care

The postoperative strapping of the large varices down the leg is just as important here as after the simple injections. The veins are usually larger. The varices not thrombosed after the initial injections are injected later at the office just as rapidly as the additional injections can be tolerated by the patient. This is usually started on the seventh to tenth postoperative day and is continued from week to week until all the varicose veins have been treated. The patient is then instructed to return from month to month for inspection, and at the end of one year, postoperative, he is discharged to return once a year the rest of his life. It is only with this careful, consistent, follow-up care and treatment of the new varicose veins as they form from year to year that we may hope to keep the varicose condition under control. If this is done, we can assure the patient that he has no cause to worry about having such a condition as he formerly possessed.

The more I see of this work and the cases treated by other doctors, the more firmly convinced I am that the good results or failures are in direct proportion to the interest in and care given to the individual patient. I believe that there is no one condition in medicine that shows this more. Until we can raise the treatment of varicose veins to a status which will lead the doctor to appreciate that he has a real responsibility to the patient and not regard the case as though it were "just another sore leg with varicose veins," just until that time will the results of the treatment of these patients be haphazard and, to a large degree, poor and unsuccessful. May the day soon come when physicians at large will either refer these patients to the man who does care to spend the time needed for their treatment or assume *their* proper responsibility and learn to do it well themselves.

Comments on Treatment

Editors—A. J. QUICK, M. D., Marquette University, Milwaukee, and
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Swimmer's Itch

With the opening of the swimming season, physicians of the state—especially those in the lake districts—will be called upon to treat a peculiar pruritic condition commonly called swimmer's itch. The causative factor is usually cercaria stagnicolae. The organism belongs to the family of the schistosoma. It is widely distributed and, oddly enough, often infests the clear water lakes in the glacier districts, which one would least suspect. It is generally accepted that migratory birds such as wild ducks harbor the adult schistosome worms. The eggs or ova which they produce are eliminated in the droppings of these aquatic birds. In this manner, the natural waters, especially inland lakes, become infested. The embryos which develop enter the bodies of snails and then emerge as free swimming larval trematodes—*the cercariae.* These measure approximately 0.7 mm. and are just visible to the naked eye. The cercariae seek their natural host, the migratory aquatic birds, where they again develop into adult schistosomes. If the cercariae encounter a human being, they likewise penetrate the skin. Fortunately, man is not a suitable host, and the organism dies before it reaches structures deeper than the skin. Therefore, there is no danger of systemic involvement; the effect is purely local.

Immediately after the cercariae penetrate the skin of a human being, a tingling sensation is experienced, and a pin-point redness appears. Several hours later, marked itching occurs, and the macular rash changes to one papular in type. As a result of scratching, the area becomes hyperemic and often secondarily infected to the extent that pustules appear. Usually the itching disappears in a few days, but the rash may require two or more weeks before it fades completely.

The most effective method for the prevention of swimmer's itch is thorough rubbing of the skin with a dry towel immediately after the swimmer leaves the water. By this simple means, the tiny larvel schistosomes are crushed and removed from the skin before they have a chance to penetrate. It seems well worth giving publicity to this simple preventive measure, since swimmer's itch may seriously affect the summer tourist trade.

After the penetration of the cercariae into the skin, nothing can be done except to treat the patient symptomatically for the intense pruritis. This is best accomplished by calamine lotion or ointment with 1 per cent phenol.

Since swimmer's itch is of definite economic interest in Wisconsin, efforts to control the spread of cercaria stagnicolae is important. Since part of the life cycle of the organism is passed in the snail, the elimination of the latter is the most satisfactory approach to the problem. Brackett (formerly of the University of Wisconsin) and McMullen[1] have found that a mixture of two pounds of copper sulfate and one pound of copper carbonate per 1,000 square feet of water surface is the most effective known method for ridding lakes of their snail population. The treatment is effective for only one season and, therefore, must be repeated annually. No harmful effect on fish occurs.
A. J. Q.

[1] McMullen, D. B., and Brackett, S.: The Distribution and Control of Schistosome Dermatitis in Wisconsin and Michigan, Am. J. Trop. Med. 21:725, 1941.

In accordance with a recent Post Office request, all mail addressed to this office should be as follows: State Medical Society of Wisconsin (or Wisconsin Medical Journal), 917 Tenney Building, Madison 3, Wisconsin. Be sure the "3" is inserted between "Madison" and "Wisconsin."

The Nation at War

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Douglas County Emergency Medical Service Establishes Blood Plasma Unit

Under the direction and supervision of Dr. V. E. Ekblad, Chief of Emergency Medical Service for Douglas County, the St. Mary's Hospital secured a grant from the office of Civilian Defense to assist in the establishment of this unit.

Left to right: Sister Claudia, in charge of laboratory; Dr. G. L. Berdez; Miss Lundstrom, chief surgical nurse, and Dr. V. E. Ekblad.

The first donor to the blood plasma bank in Superior was Bishop O'Connor, who is shown in one of the accompanying photographs. Since the establishment of the unit, a total of 300 donors have contributed to the bank. A constant inventory of 250 units of plasma will be maintained at the hospital.

Great assistance was rendered to the Douglas County Emergency Medical Service unit and the hospital by the American Red Cross in obtaining donors for the bank.

With the establishment of the plasma reserves in Superior, there are now 1,550 units available in Wisconsin in the event of enemy action. The distribution of the units is as follows: Superior, 100 units dried plasma, 250 units frozen plasma; Eau Claire, 100 units dried plasma, 300 units frozen plasma; Madison, 200 units dried plasma; Oshkosh, 100 units dried plasma; Milwaukee, Columbia Hospital, 500 units frozen plasma.

Additional units of dried plasma have been definitely allocated to Wisconsin, and it is anticipated they will be received by early fall.

In addition to the inventory above, plans are going forward in Dane County under the supervision of Dr. J. S. Supernaw, State Chief of Emergency Medical Service, Dr. H. M. Coon, Superintendent of Wisconsin General Hospital and Dr. W. D. Stovall, Director, State Laboratory of Hygiene, for the establishment of additional reserve units that may be drawn upon in the event that enemy action reaches Wisconsin. With the contemplated reserves which will be created

Left to right: Father Weber, Bishop O'Connor, Miss Lundstrom, and Dr. J. W. McGill.

by this new bank together with the dried plasma units scheduled for Wisconsin, we may expect to have a total of well over 2,000 blood plasma units for use by Emergency Medical Service in our state. This is considered adequate in the light of present conditions.

This plasma is available through the established Civilian Defense organizations in the several counties. In the event a community disaster occurs, this plasma may be drawn upon through a request made to the County Chief of Emergency Medical Service in the county in which the incident occurs, or through one of the Assistant State Chiefs of Emergency Medical Service, or through Dr. J. S. Supernaw, State Chief of Emergency Medical Service.

Medical Administrative Corps

One of the most rapidly growing officer corps in the Army at the present time is the Medical Administrative Corps, a nonmedical group which is combining its knowledge of supply, evacuation, personnel, and training methods of the Army to work with the professional men in making the Army Medical Department the worker of miracles that it is.

Noncommissioned officers from all branches of the service train at the Medical Administrative Officer Candidate School at Camp Barkeley, Texas, having been carefully chosen by selecting boards. A large number of the candidates come from the Medical Department's enlisted men and often have highly specialized civilian training in such fields as pharmacy, drug sales, embalming and mortuary, chemistry, hospital administration, and premedical training.

These picked men are given a tough, intensive course at the Camp Barkeley school, the only Medical Administrative school since Caslisle Barracks, Pennsylvania, was taken over completely by the medical field service school in March. Courses in logistics, tactics, sanitation, administration, chemical warfare, and allied subjects enable the new second lieutenants to qualify for practically any job in the Medical Department which does not require professional skill, positions which Medical Corps men have often been forced to undertake instead of medical and surgical work.

The school at Camp Barkeley is now working overtime to turn out new second lieutenants, graduating a class of from 200 to 400 officers every two weeks. There have been over 6,000 graduates of the school in the year of its operation, Class XVI being graduated on May 26.

News of Families Most Welcomed by Men in Military Service

Army-OWI Survey Shows Letters From Home Have Strong Effect on Soldiers' Morale

The news most welcomed by America's fighting men is family news, the Office of War Information reported last week in making public the results of a survey among men in the armed services in this country and overseas.

According to the OWI the kind of letters the man in the armed services wants are the cheerful, newsy ones from his relatives and friends. He does not like "fan letters" written by strangers who happened to join a "Write a Fighter" club. Letters by a hero-worshiping youngster who picked up his name from a schoolmate mean little to him.

Newspapers Welcomed

He likes to get newspaper clippings especially from home-town newspapers. And though he appreciates the sentiment, he does not get much good out of packages of food. He is a well-fed boy to begin with, and anyway cakes and candies are likely to arrive in such condition that they are inedible.

While the man in service is interested in the war at home and how his friends are backing him up with rationing and volunteer war work, he does not want to hear about people back home being deprived of things. Even if complaining is set aside, he doesn't want to be told about troubles the people back home are having. He has plenty of troubles of his own. A soldier can be so worried about a serious situation back home—a situation he can't do anything about—as to

have his attention distracted from the very grim task of taking care of his own life.

"We speak of mail building the soldier's morale," says Brigadier General Adams, Chief of the Army Postal Service. "Well, mail can also ruin a soldier's morale, if it's the wrong kind of letter."

News for Overseas

At one station overseas representative enlisted men were asked "What kind of things do you like to read about in your letters from home?" An examination of answers showed that soldiers like to receive letters which tell them how their families are getting along economically. They also like to read that their families are doing everything possible to aid the war effort and are anxious for the return of their boys. Even if soldiers receive letters indicating only that their families are "okay and busy," it means a great deal to them.

Soldiers also like to hear news about their friends, especially those in the service, and about the girls they know (if they are single). News about friends at home is welcome, as is news of changes in social relations (who is marrying whom). Past events, places he used to go, and the community's "night life" are also matters of interest to soldiers.

News about the home town such as general happenings, general gossip, and sports news (especially the home teams), are other items which interest soldiers.

Present conditions—the effect the war is having on the home town, rationing, business—are additional points soldiers like letters to cover.

Military Notes

A letter to *The Journal* from Dr. Robert E. Fitzgerald, chairman of the Procurement and Assignment Service for Physicians in Wisconsin, advises us of the following: "It may be of interest for you that five of our colleagues are in a concentration camp in Tokio. They are Dr. Leasum of Sturgeon Bay, Dr. Sitter of Oshkosh, Dr. Tousignant of Oconto, and Dr. Shabart and Dr. Wernitznig of Milwaukee. They are wistfully awaiting release so that they may be able to come home to their wives, children and friends. The only way this will be possible is to increase the size of our Army, and by so doing, the need for further doctors will be also increased."

—△—

Captain Bernard C. Dockendorff, formerly of Arcadia, was promoted to the rank of captain on April 1. Still located at Camp McCoy at Sparta and assigned to the Station Hospital on surgical service, he finds his medical activities interesting and demanding in that he and his associates are working with the newest technics and ideas. He appreciates receiving the news letters and *The Journal.*

—△—

In a card to the office of the Secretary, **Lieutenant Joseph F. Kelley** indicates that he is now attending school at Orlando, Florida. Formerly of Janesville, he finds the Florida weather very warm but likeable.

—△—

Major Leo R. Weinshel, chief of surgical service at the Army Air Forces Advanced Flying School, Moody Field, Georgia, is co-author with Lieutenant Nicholas Demakopoulos of the article "Supernumerary Breasts," which appeared in the April, 1943, issue of *The American Journal of Surgery.* Major Weinshel formerly practiced in Milwaukee.

ROSTER OF WISCONSIN PHYSICIANS IN SERVICE

At the request of the Procurement and Assignment Service in Wisconsin, *The Journal,* beginning with the August issue, will publish a complete roster of Wisconsin physicians who are in service with the armed forces. No service address will be given for these men, but only the location which they left to enter service. To assist the Society in preparing and maintaining this roster, officers of the county medical societies are asked to send the office of the State Medical Society any recent information concerning men who have enrolled and have reported for active duty.

HOTEL RESERVATIONS

Reservation of hotel room gives greater assurance that the accommodations you desire will be available to you during your stay in Milwaukee.—Make your reservation now!

THE WISCONSIN MEDICAL JOURNAL

The Council on Scientific Work

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« « « EDITORIALS » » »

Positive Accomplishment

MEDICINE has an inquiring mind, innate to the profession because of its continuous search for better ways and means for the protection and promotion of the public health. Because of that inherent characteristic, it sometimes seems to others that medicine is never satisfied, and, in fact, it is not. Yet, there are occasions when the profession of medicine can do well to pause and review the record of the past.

With the recess of the sixty-sixth legislative session of the State of Wisconsin, the medical profession will do well to review the public health problems that were before the legislature and the Executive Office of this state. It is a trite observation to note that in time of national stress, it is most difficult for all to maintain a proper perspective with reference to relative values. So far as public health matters are concerned, those that have been brought before the legislature and our Executive Office have received serious and careful attention.

Witness these facts: appointments of outstanding individuals to the State Board of Health; the responsibilities given the medical profession in civilian defense and the Procurement and Assignment Service; the defeat of two bills which would have removed private medical practice as it affects 2,000,000 people of the State of Wisconsin and would have barred all restrictions of good judgment and business sense as they relate to any form of medical practice. Witness, further, the fact that of the several proposals of the chiropractors, none passed even the house in which first introduced. Witness the passage and the signing into law of each of the five legislative measures which the State Medical Society of Wisconsin actively sponsored and endorsed before this session of the legislature. The annual registration law for physicians, the laws relating to the salaries of the state health officers and his deputies, the law relating to licensed attendants, and the change in the law relating to emergency medical care given hospitalized indigents, all were enacted into law.

Not since the days of the Basic Science Law nearly two decades ago has there been more positive accomplishment in the interests of the public health.

This is a tribute to no one organization and to no one individual. It is the cumulative effort of a state medical society respected by the legislators and public officials for its honest, consistent and unbiased efforts in the field of public health. The physicians of the state may be justly proud,—justly proud of the legislators who themselves exhibited unlagging interest in matters of vital public health concern—justly proud of the interest shown by the Executive Office of this state and, above all, justly proud that the creed developed by that individual who for so long articulated the voice of medicine in Wisconsin proved its value and its farsighted wisdom.

> "The interests of public health are identical to those of medicine. Whatever will promote the public welfare, whatever will protect the advances already made—these are medicine's only objectives."

"Irresistible"

DR. F. E. Butler, the beloved and esteemed president of the Wisconsin State Medical Society, died early in March this year. One of the last things he did was to publish on the President's Page of *The Wisconsin Medical Journal,* an editorial entitled, "Irresistible." Therein, he quoted from Professor Harley L. Lutz of Princeton University. "Few people realize that what is called a great social trend is no more than the propaganda put out by the opponents of a free society to confuse, disorganize and disarm the defenders of that society. There is no such thing as an irresistible social trend. It only becomes so when every one ceases to resist it."

In support Dr. Butler stated, "We shall continue to reiterate our opinion that a highly technical service is not a skill which like a commodity can be packaged and sold. Its quality in the United States can be measured largely by its accomplishments in a free society. Dilution by artificial limitations will neither protect our present standards of medical care (dental care may be substituted) nor promote the public welfare."

Those who believe that medical (or dental) care could be more generally available through a system of socialization do not realize that *cheapened* care would be substituted for *cheaper* care!

We wonder if this lofty idealism is a true reflection of the general membership of the medical and dental professions. The little wedges of socialization, county relief, F.S.A., N.Y.A. and the many trial balloons of social workers seem to have little trouble in getting co-operation from both dentists and physicians. The security of a limited income seems to appeal more to many than the chances taken in a free enterprise. If our status quo is to continue, much bolstering must be done to a large percentage of our health profession's members.—Editorial, *The Journal of the Wisconsin State Dental Society,* May–June, 1943.

A NEW SOUND FILM STRIP AVAILABLE

The Society has obtained for the use of its members a sound film strip entitled "Keep Out Infection." It is composed of a series of still pictures in one continuous film strip. Accompanying the strip is a phonograph record explaining each of the pictures to the audience.

This film is designed for showing before lay audiences and can be used by members of the Society as visual aid in connection with public appearances. It is particularly adaptable for showing before industrial employes.

The film, together with the record, may be obtained on request from the Secretary's office, 917 Tenney Building, Madison 3, Wisconsin.

. . . . THE PRESIDENT'S PAGE . . . .

TWO years have elapsed since I had the privilege of being president of our Society and the honor of serving during the Centennial Anniversary year. We have now begun our second century as a Society, a period with tremendous social and economic changes in the making.

Although the war is now our chief concern and must remain so until this great hazard to our people reaches a favorable conclusion, we must be mindful of the postwar status of medicine and of how we as physicians are going to fit into the picture.

Considering the statistics of increased longevity and the tremendous improvement in the health of our people which has occurred largely within the last twenty-five years, one views as an absurdity the readiness of the politicians to challenge in advance the health of the coming quarter of a century. When medicine stands still or becomes decadent will be the time to expose us physicians to the jury of public opinion.

Our state organization, as well as practically all others throughout the United States, is mindful of the insidious forces which have been working to change medicine as we have known it. The question arises as to how we should approach the problem. Should we stand by and hope that we may fare well, or should we comprise an active, positive force to preserve the principles which have governed the art of healing since Hippocrates?

The splendid voluntary response of 48,000 physicians in this country to the colors is an achievement without parallel. The excellent medical care which our armed forces are receiving from one-third of the members of the American Medical Association will have exerted a strong influence upon public opinion, an influence which should forcibly counteract the intensified efforts of postwar reformers.

R. P. SPROULE, *Past-president.*

HEALTH
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CHEMOTHERAPY
MEDICINE
AT HOME and IN WAR
anniversary
WISCONSIN

One Hundred Second Anniversary Meeting to Be Featured By Wartime Program

CHANGING technics in the treatment of the sick as a result of the war will be emphasized at the One Hundred Second Anniversary Meeting of the State Medical Society of Wisconsin to be held in Milwaukee September 13, 14 and 15. Diseases known to Wisconsin physicians only from text book discussions and illustrations may well become actual clinical pictures among the patients seen daily by members of the Society.

The attention of Wisconsin physicians will be focused upon tropical diseases and the several types of rehabilitation that are part and parcel of a global war. Members of the armed services returning from the tropics will, in all probability, inadvertently bring with them diseases contracted during the period of their military service. The problem of rehabilitating members of the armed services is already on us in Wisconsin. Mental disease or the loss of an arm or a leg constitute problems of rehabilitation in order to return these cases to gainful occupations.

After virtually a year of intensive planning and effort, the Council on Scientific Work has completed the scientific program. Final revisions were effected at a recent meeting of the Council, under whose guidance Dr. F. D. Murphy, Milwaukee, developed and perfected the program.

James E. Paullin

It is the prerogative of the president each year to arrange the program for the Annual Dinner. Dr. R. M. Kurten, president of the Society, has received an acceptance from Dr. Paullin, president of the American Medical Association, to be the principal speaker at the Society's Annual Dinner which will be held on Tuesday evening, September 14, at the Hotel Schroeder. The subject of Dr. Paullin's presentation will be "The Role of the Medical Profession in Planning for Post-War Medical Service."

Symposiums

One of the primary reasons for the creation of the Council on Scientific Work was to assure coordination in the presentation of scientific material at each year's meeting. This year Dr. Murphy has so arranged the scientific program as to carry out plans formulated last year by the Council on Scientific Work. The symposiums presented at the 1942 meeting included one on the heart, one on hemorrhage, and still a third one on the sulfonamides. The symposiums to be presented this year include one on the liver, another on gastric ulcers, and a third on the physician and the war.

Admiral Ross T. McIntire, Surgeon General of the United States Navy

One of the outstanding guest speakers scheduled to appear on the program in September is Admiral Ross T. McIntire, Surgeon General of the Navy, who will discuss on the Monday afternoon program the subject "Preparation of Physicians for the Armed Services."

Other Army, Navy and Civilian Defense personnel scheduled to address the meeting are Captain W. E. Eaton, Medical Officer in Command, Great Lakes, Illinois; Major C. S. Higley, Chief of Medical Service, Truax Field, Madison, and Dr. J. S. Coulter, Regional Officer of Medical Defense, Chicago.

Scientific Exhibits

The continuity and the correlation referred to above will be carried forward in the scientific exhibit section by Dr. C. D. Neidhold of Appleton, who is a member of the Council on Scientific Work and who has made a studied effort to have the scientific exhibits demonstrate the subjects presented in the general sessions. To this end, the wet specimen anatomy exhibits of the Marquette University School of Medicine and the University of Wisconsin Medical School will emphasize the anatomy and pathology of the liver and the gastrointestinal tract. The

popularity of the wet specimen exhibits is demonstrated each year by the concentrated interest that is evidenced by the large number of physicians who visit these exhibit booths.

An exhibit on tropical diseases will be presented by Dr. Marcos Fernan–Nunez, professor of pathology, Marquette University School of Medicine. Dr. Nunez is a recognized authority on tropical medicine, having obtained much of his early training at the Central University, Madrid, Spain. This exhibit will be correlated with his presentation of the same subject on the general session program.

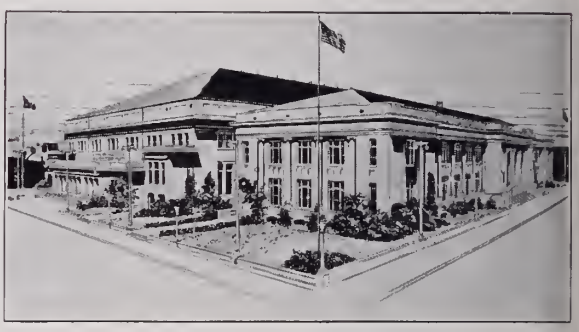
While this year's scientific exhibits are listed in outline form in this issue of *The Journal,* a full description of them will be given in the August issue.

Secretaries' Conference

Tentative plans call for a conference of secretaries and presidents of county medical societies on Sunday, September 12, at the Hotel Schroeder. This meeting will precede the meeting of the House of Delegates. A complete program will be included in a subsequent issue of *The Journal.*

House of Delegates

The House of Delegates is scheduled to hold its initial meeting on Sunday, September 12, at 6:30 p. m. All members of the Society are invited and urged to attend by Dr. Charles Fidler, speaker of the House. Of course, only members of the House of Delegates are permitted to vote.



Milwaukee Auditorium.

SUNDAY EVENING, SEPTEMBER 12 . . .

6:30 **House of Delegates**
Banquet Room (Fifth Floor), Hotel Schroeder

MONDAY MORNING, SEPTEMBER 13 . . .

7:30 REGISTRATION
Milwaukee Auditorium

BREAKFAST ROUND TABLES 7:30—8:45 P. M.

Hotel Schroeder

1. Bedside Medicine and Newer Drugs
   Ovid O. Meyer, associate professor of medicine, University of Wisconsin Medical School, Madison
2. Prevention and Treatment of Wound Infections
   Joseph M. King, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee
3. Improvisations to Cope with Medical and Surgical Emergencies in the Home
   Justin D. Leahy, Park Falls
4. Precautions in Absentee Diagnosis, Treatment and Prescribing by Telephone
   Joseph Lettenberger, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee
5. Medication for Common Skin Diseases
   Maurice J. Reuter, Milwaukee
6. Obstetrical Anesthesia
   Arthur A. Cantwell, Shawano

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Subject to be Announced

Symposium on the Liver

9:00 Physiology of the Liver
Frank C. Mann, professor of pathology and experimental physiology and surgery, University of Minnesota Graduate School, Rochester, Minnesota

9:20 Studies of Liver Disease with Correlation of Clinical Features and Liver Function Tests
Cecil J. Watson, professor of internal medicine, University of Minnesota Medical School, Minneapolis, Minnesota

GENERAL SESSION (Continued)

9:40 Differential Diagnosis of Jaundice
Marion A. Blankenhorn, professor of medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio

10:00 Recess to View Exhibits

10:30 Surgery of the Biliary Tract
Carl W. Eberbach, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee

10:50 Preoperative and Postoperative Complications and Treatment of the Jaundiced Patient
Matthew A. McGarty, La Crosse

11:10 Summary and Discussion of These Papers
Warren H. Cole, professor of surgery, University of Illinois College of Medicine, Chicago, Illinois

11:30 Recess to View Exhibits

MONDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. Liver Function Tests and Their Clinical Value
   Cecil J. Watson, Rochester, Minnesota
2. Jaundice
   Marion A. Blankenhorn, Cincinnati, Ohio
3. Surgical Advances from the War
   Warren H. Cole, Chicago
4. The Navy's Demand on the Scientific Training of the Medical Officer
   Rear Admiral Ross T. McIntire, Surgeon General of the United States Navy, Washington, D. C.
5. The Relation of Peptic Ulcer to Cancer of the Stomach
   George B. Eusterman, professor of medicine, University of Minnesota Graduate School, Minneapolis
6. Hepatorenal Syndrome
7. When Is Peptic Ulcer a Medical and When Is It a Surgical Problem?
   Donald C. Balfour, professor of surgery, University of Minnesota Graduate School, Rochester, Minnesota
8. Thyroid Surgery
9. Breast Surgery
   Frederick A. Stratton, clinical professor of surgery, Marquette University School of Medicine, Milwaukee
10. Colitis
    Joseph Shaiken, Milwaukee
11. Acute Appendicitis: Treatment
    Erwin R. Schmidt, professor of surgery, University of Wisconsin Medical School, Madison
12. Treatment of Eye Conditions Encountered by the General Practitioner
    Ferdinand H. Haessler, Milwaukee
13. Ear Conditions in General Practice
    William E. Grove, clinical professor of otolaryngology, Marquette University School of Medicine, Milwaukee
14. What Drugs to Use in the Treatment of Diseases of the Heart
    Chester M. Kurtz, Milwaukee, associate professor of clinical medicine, University of Wisconsin Medical School, Madison
15. New Conceptions in the Administration of Immunization for Whooping Cough and Other Contagious Disease Serums and Vaccines
    William D. Stovall, professor of hygiene, University of Wisconsin Medical School, Madison
16. Radiologic Problem Clinic for the General Practitioner
    Silvanus A. Morton, Milwaukee
17. Obstetrics in the Home
    Woodruff Smith, Ladysmith
18. Pediatric Practice in the Office and Home
    Abraham B. Schwartz, assistant clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee
19. Chemotherapy in the Urinary Tract Diseases
    Hartwick M. Stang, Eau Claire
20. Influence of Surgery on Tuberculosis
    Anthony V. Cadden, Muirdale Sanatorium, Wauwatosa

MONDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

Symposium on Peptic Ulcer

2:00 Etiology, Pathology and Incidence of Peptic Ulcer
Frederick A. Stratton, Milwaukee

2:20 Bleeding Peptic Ulcer

2:20 Medical Treatment
Joseph Shaiken, Milwaukee

2:40 Surgical Treatment
Russell M. Kurten, Racine, president, The State Medical Society of Wisconsin

3:00 Recess to View Exhibits

GENERAL SESSION (Continued)

3:30 Preparation of Physicians for the Armed Services
Rear Admiral Ross T. McIntire, Surgeon General of the United States Navy, Washington, D. C.

3:50 Observations on Gastric Carcinoma in Its Earliest Stages
George B. Eusterman, Rochester, Minnesota

4:10 Operation of Choice in Peptic Ulcer
Erwin R. Schmidt, professor of surgery, University of Wisconsin Medical School, Madison

4:30 Discussion and Summary of Symposium
Donald C. Balfour, Rochester, Minnesota

Scientific Motion Pictures

MONDAY EVENING . . .

6:45 **House of Delegates**
Banquet Room (Fifth Floor), Hotel Schroeder

8:00 **Smoker**

TUESDAY MORNING, SEPTEMBER 14 . . .

8:00 **House of Delegates**
Banquet Room (Fifth Floor), Hotel Schroeder

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Subject to be Announced

9:00 Problems in Plastic Surgery of the Face
C. R. Dix, Milwaukee

9:20 The Place of Sulfonamides in Surgery
Arnold S. Jackson, Madison

9:40 Psychiatric Problems Arising from Military Service
John Romano, professor of psychiatry, University of Cincinnati College of Medicine, Cincinnati, Ohio

10:00 **Recess to View Exhibits**

10:30 Virus Diseases of Man
Edward R. Krumbiegel, assistant clinical professor of public health, Marquette University School of Medicine, Milwaukee

10:50 Reports of Officers

11:10 Address of President

TUESDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. Medical Problems Confronting Asylum Physicians and Superintendents
   Henry H. Christofferson, Colby, chairman, Committee on Mental Hygiene and Institutional Care
2. Psychiatric Examination in General Practice
   Saul K. Pollack, Milwaukee
3. Transfusions and Fluid Balance
   Frederick A. Coller, professor of surgery, University of Michigan Medical School, Ann Arbor, Michigan
4. Treatment of Patients Suffering from Wounds due to Poison Gas
   Raymond F. Wagner, Oshkosh
   Anthony R. Curreri, assistant professor of surgery, University of Wisconsin Medical School, Madison
   Elston L. Belknap, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee
5. Sulfonamides in Surgical Practice
   Arnold S. Jackson, Madison
6. Diagnosis and Treatment of Cancer of the Bowel
   Claude F. Dixon, associate professor of surgery, University of Minnesota Graduate School, Rochester, Minnesota
7. Diseases of Viral Etiology
   Edward R. Krumbiegel, Milwaukee

ROUND-TABLE LUNCHEONS (Continued)

8. Anemias and Leukemias
   Frederick W. Madison, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee
9. Emotional Disorders in Selective Service
   Major John A. Grab, M. C., United States Selective Service, Madison
10. Virus Pneumonia: Diagnosis and Complications
    Alvin G. Koehler, Oshkosh
11. Soldier's Heart
    Major Paul L. Eisele, M. C., United States Selective Service, Milwaukee
12. Treatment of Coronary Occlusion
13. Physical Therapy Department for Convalescents in General Hospitals
    Frances A. Hellebrandt, associate professor of physical medicine, University of Wisconsin Medical School, Madison
14. Poliomyelitis: Immediate and Remote Results
    Eben J. Carey, dean and professor of anatomy, Marquette University School of Medicine, Milwaukee
15. Irradiation Treatment of Carcinoma (External)
    Harry R. Foerster, assistant professor of dermatology, University of Wisconsin Medical School, Madison, and assistant clinical professor of dermatology, Marquette University School of Medicine, Milwaukee
16. Psychosomatic Medicine
    John Romano, professor of psychiatry, University of Cincinnati College of Medicine, Cincinnati, Ohio
17. Medical Problems Created by Employment of Women in Industry
    Paul A. Brehm, director, Industrial Hygiene Unit, State Board of Health, Madison
    Herbert G. Brehm, Racine
    Mr. G. F. Nuernberger, supervisor, Health and Safety Division, Industrial Relations Department, Allis Chalmers, Milwaukee
18. Fracture Problems
    Robert P. Montgomery, Milwaukee
19. Local Anesthesia in Sprains and Strains
    Walter P. Blount, Milwaukee
20. Induction of Labor
    George W. Walter, Racine
    Arthur A. Cantwell, Shawano

TUESDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

2:00 Uses of Blood Substitutes in Hemorrhage, Shock and Protein Deficiencies
Frederick A. Coller, professor of surgery, University of Michigan Medical School, Ann Arbor, Michigan

2:20 Immediate and Remote Complications of Sulfonamide Therapy
John C. Grill, associate professor of pathology and bacteriology, Marquette University School of Medicine, Milwaukee

2:40 Medical Aspects of Chemical Warfare
John S. Coulter, associate professor of physical therapy, Northwestern University Medical School, Chicago

3:00 Recess to View Exhibits

3:30 Present Status of Hemorrhagic Diseases
Frederick W. Madison, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee

3:50 Cancer of the Bowel: Surgical Treatment
Claude F. Dixon, associate professor of surgery, University of Minnesota Graduate School, Rochester, Minnesota

4:10 A Contrast of Selective Service and United States Army Physical Examinations
Major John A. Grab, M. C., United States Selective Service, Madison

4:30 Scientific Motion Pictures
Subject to be Announced

WEDNESDAY MORNING, SEPTEMBER 15 . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Subjects to be Announced

SECTION ON HOSPITAL RELATIONS . . .

Chairman: John E. Habbe, assistant clinical professor of roentgenology, Marquette University School of Medicine, Milwaukee

9:00 Professional Accounting
Harold M. Coon, professor of hospital administration, University of Wisconsin Medical School, Madison

9:20 Problems Concerning Graduate Education and Employment of Nurses, Interns and Residents
William A. O'Brien, professor of personal health and health education, University of Minnesota Medical School, Minneapolis

9:40 Hospitals in the Selection of Medical Staffs
Mr. J. W. Holloway, Jr., director, Bureau of Legal Medicine and Legislation, American Medical Association, Chicago

10:00 Recess to View Exhibits

10:30 Interhospital Relations
William A. Coventry, Duluth, Minnesota

10:50 The Hospital Library
Gorton Ritchie, Racine

11:10 Administrative and Professional Problems of Medical Practice in the Hospital
Speaker to be announced

11:30 Recess to View Exhibits

NOON LUNCHEON

Hotel Schroeder

12:00 Future Joint Problems of Medicine and the Hospitals
Father Alphonse M. Schwitalla, S. J., Ph. D., dean, St. Louis University School of Medicine, St. Louis, Missouri

SECTION ON INTERNAL MEDICINE AND CARDIOLOGY . . .

Chairman: Alvin G. Koehler, Oshkosh

8:40 Neurologic Conditions of Interest to the General Practitioner
John L. Garvey, clinical professor of neurology, Marquette University School of Medicine, Milwaukee

9:00 Chronic Diseases of the Lung Mistaken for Tuberculosis
Anthony V. Cadden, Muirdale Sanatorium, Wauwatosa

9:20 Recognition of Early Myocardial Failure
Chauncey C. Maher, associate professor of medicine, Northwestern University Medical School, Chicago, Illinois

10:00 Recess to View Exhibits

10:30 Rheumatic Fever: Diagnosis and Treatment
Paul S. Rhoads, associate professor of medicine, Northwestern University Medical School, Chicago

10:50 Treatment of the Various Pneumonias
Major C. S. Higley, Truax Field, Madison

11:10 Recent Advances in Diabetes Mellitus
Elwood W. Mason, Milwaukee

11:30 Recess to View Exhibits

SECTION ON OBSTETRICS AND GYNECOLOGY . . .

Chairman: Robert L. Cowles, Green Bay

9:00 Prenatal Care

9:20 Discussant:
Roger C. Cantwell, Shawano

9:30 Endocrines in Obstetrics
Ralph E. Campbell, associate professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison

9:50 Discussant:
Elmer L. Sevringhaus, professor of medicine, University of Wisconsin Medical School, Madison

10:00 Recess to View Exhibits

10:30 Diabetes in Pregnancy
George S. Kilkenny, Milwaukee

10:50 Discussant:
Roland S. Cron, clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee

11:00 Sterility
Ralph A. Reis, assistant professor of obstetrics and gynecology, Northwestern University Medical School, Chicago

11:20 Discussant:
Carl S. Harper, assistant clinical professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison

11:30 Recess to View Exhibits

SECTION ON OPHTHALMOLOGY . . .

Chairman: William E. Grove, clinical professor of otolaryngology, Marquette University School of Medicine, Milwaukee

9:00 The Eye in General Diagnosis
Sanford R. Gifford, professor of ophthalmology, Northwestern University Medical School, Chicago

9:20 Vision in Anisometropia
Lyman A. Copps, Marshfield Clinic, Marshfield

9:40 Discussion
Jasper M. Molsberry, Milwaukee

10:00 Recess to View Exhibits

10:30 Complications in Cataract Surgery
Raymond C. Warner, Milwaukee

10:50 Discussion
Frederick A. Davis, professor of ophthalmology, University of Wisconsin Medical School, Madison

11:00 Evaluation of Blood Studies in Postoperative Bleeding after Cataract Surgery
Eugene E. Neff, associate professor of ophthalmology, University of Wisconsin Medical School, Madison

11:20 Discussion
F. Herbert Haessler, Milwaukee

11:30 Recess to View Exhibits

SECTION ON ORTHOPEDICS . . .

Chairman: Robert E. Burns, professor of orthopedic surgery, University of Wisconsin Medical School, Madison

9:00 Posture in School Children
David J. Ansfield, Milwaukee

9:30 The Value of Early Recognition of Congenital Dislocation of the Hip
Vernon C. Turner, Milwaukee

10:00 Recess to View Exhibits

10:30 Sequelae of Fractured Hips and Their Treatment
Chester C. Schneider, Milwaukee

11:00 Low Back Injuries and Compensation Cases
W. E. Wolcott, Green Bay

11:30 Recess to View Exhibits

SECTION ON PEDIATRICS . . .

Chairman: Henry A. Sincock, Superior

9:00 Better Health for Children: Physicians and the Social Security Program
Hart E. Van Riper, assistant director for maternal and child health, Division of Health Services, Washington, D. C.

9:20 Reducing the Hazards of the First Week of Life
John W. Prentice, Ashland

9:40 The Infant Larynx
Paul H. Holinger, assistant professor of laryngology, University of Illinois College of Medicine, Chicago

10:00 Recess to View Exhibits

10:30 Immunization in Pediatrics Practice
Edgar J. Huenekens, clinical professor of pediatrics, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis; member of the Immunization Committee of the American Academy of Pediatrics

10:50 Discussant:
A Member of the Health Department of the City of Milwaukee

11:00 Malocclusion and Malformations of the Jaws and Face in Children Necessitating Early Orthodontic and Surgical Care
Matthew N. Federspiel, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee

11:30 Recess to View Exhibits

SECTION ON RADIOLOGY . . .

Chairman: Lester W. Paul, Madison

9:00 Business Meeting of Section

9:30 Experiences with Priodax, a New Dye for Gallbladder Visualization
Hans W. Hefke, Milwaukee

9:50 Discussion

10:00 Recess to View Exhibits

10:30 Round-Table Discussion with Case Reports
William T. Clark, Janesville
Theodore Sokow, Kenosha
Silvanus A. Morton, Milwaukee
Ernst A. Pohle, Madison
Ivan G. Ellis, Madison
Lester W. Paul, Madison

11:30 Recess to View Exhibits

SECTION ON SURGERY . . .

Chairman: Dexter H. Witte, Milwaukee

9:00 Infections and Surgery of the Hand

9:20 Discussion
Thomas S. O'Malley, Milwaukee, plant surgeon, A. O. Smith Corporation

9:30 Inproved Surgical Treatments of Hernias
Leo M. Zimmerman, assistant professor of surgery, Northwestern University Medical School, Chicago

9:50 Discussion
Irwin Schulz, Milwaukee

10:00 Recess to View Exhibits

10:30 Plastic Surgery
James B. Brown, associate professor of clinical surgery, Washington University School of Medicine, St. Louis

10:50 Discussion
Volney B. Hyslop, professor of oral and plastic surgery, University of Wisconsin Medical School, Madison

11:00 Intravenous Use of Amino Acids
Anthony R. Curreri, assistant professor of surgery, University of Wisconsin Medical School, Madison

11:20 Discussion

SECTION ON UROLOGY . . .

Chairman: Walter M. Kearns, Milwaukee

9:00 Subject to be Announced
Hartwick S. Stang, Eau Claire

9:20 Management of Ureteral Stone
Alexander D. Spooner, Milwaukee

9:40 Upper Urinary Tract Problems in Infants and Children
N. Warren Bourne, Milwaukee

10:00 **Recess to View Exhibits**

10:30 Discussion of Urinary Tract Injuries
Robert S. Irwin, Milwaukee

10:50 Historic Background of Litholapaxy
John L. Emmett, Rochester, Minnesota

11:10 Treatment of Resistant Infections in the Urinary Tract
Charles D. Creevy, assistant dean and professor of surgery and urology, University of Minnesota Medical School, Minneapolis

11:30 Discussion

WEDNESDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. The Problem of Tuberculosis
   Oscar Lotz, W. A. T. A., Milwaukee
2. Treatment of Heart Failure
   Chauncey C. Maher, associate professor of medicine, Northwestern University Medical School, Chicago
3. Prophylaxis of Rheumatic Fever
   Paul S. Rhoads, assistant professor of medicine, Northwestern University Medical School, Chicago
4. Skin Manifestations of Systemic Diseases
   John W. Smith, Milwaukee
5. Lung Diseases Simulating Pneumonia
   Major C. S. Higley, Truax Field, Madison
6. Paralytic Squint
   Sanford R. Gifford, professor of ophthalmology, Northwestern University Medical School, Chicago
7. Acute Upper Respiratory Infections and Their Control
   Dean M. Lierle, professor of otolaryngology, State University of Iowa College of Medicine, Iowa City, Iowa
8. Hernias and the Wisconsin Compensation Act
   Gunnar Gundersen, La Crosse, chairman, Committee on Industrial Health
   Harry A. Nelson, director, Workmen's Compensation Division, Wisconsin Industrial Commission, Madison
9. Treatment of Urinary Stones
   John L. Emmett, Rochester, Minnesota
10. Urinary Diagnosis
    Charles D. Creevy, Minneapolis
11. Environment and Child Health in the City
    Hart E. Van Riper, assistant director for Maternal and Child Health, Division of Health Services, Washington, D. C.
12. Laryngeal Disease in Infancy
    Paul H. Holinger, assistant professor of laryngology, University of Illinois College of Medicine, Chicago
13. The Prevention of Disease in Children
    Edgar J. Huenekens, clinical professor of pediatrics, University of Minnesota Medical School, Minneapolis; member of the Immunization Committee for the American Academy of Pediatrics
14. Treatment of Sterility
    Ralph A. Reis, Chicago
15. Subject in Radiology to be Announced
    Lester W. Paul, associate professor of radiology, University of Wisconsin Medical School, Madison
16. Rheumatic Heart Disease
    Vincent W. Koch, Janesville
17. The Use of Intravenous Amino Acids in General Hospital Practice
    Anthony R. Curreri, assistant professor of surgery, University of Wisconsin Medical School, Madison
18. Tropical Diseases
    Marcos Fernan-Nunez, professor of pathology and bacteriology and associate professor of public health, Marquette University School of Medicine, Milwaukee
19. Fractures That May Be Missed
    John B. MacLaren, Appleton
20. Abdominal Diagnosis in General Practice
    Lawrence D. Quigley, Green Bay

WEDNESDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

2:00 Tropical Medicine Here and in the Tropics
Marcos Fernan–Nunez, Milwaukee

2:30 Ulcer Problems in the Armed Forces
Captain William E. Eaton, M. C., U. S. N., Medical Officer in Command, U. S. Naval Hospital, Great Lakes, Illinois

3:00 Medical Education and the Armed Forces
Eben J. Carey, dean and professor of anatomy, Marquette University School of Medicine, Milwaukee

3:30 The Fate of the Practice of Medicine after the War
Alphonse M. Schwitalla, S. J., Ph. D., dean, St. Louis University School of Medicine, St. Louis, Missouri

SECTION ON OTOLARYNGOLOGY . . .

Chairman: William E. Grove, Milwaukee

2:00 Conservation of Hearing
Dean M. Lierle, professor of otolaryngology, State University of Iowa College of Medicine, Iowa City, Iowa

2:20 Vertigo and Its Treatment
Thomas L. Tolan, Milwaukee
2:40 Discussion
Thomas F. McCormick, assistant clinical professor of otolaryngology, Marquette University School of Medicine, Milwaukee

2:45 Fundamental Principles in the Diagnosis and Treatment of Respiratory Allergy
John A. Hurlbut, Madison
3:05 Discussion
William J. Frawley, Appleton

3:10 The Management of the Chronic Draining Middle Ear
Fred W. Kundert, Monroe
3:30 Discussion
William G. Meier, Sheboygan

Hotel Schroeder.

DON'T FORGET

TO

MAKE YOUR HOTEL

RESERVATION

NOW!

SCIENTIFIC EXHIBITS

The following scientific exhibits have been arranged by Dr. C. D. Neidhold of Appleton for display at the One Hundred Second Anniversary Meeting:

Applied Anatomy

Walter Zeit, Ph. D., assistant professor of anatomy, Marquette University School of Medicine, Milwaukee; and A. R. Curreri, assistant professor of surgery, University of Wisconsin Medical School; and Otto A. Mortensen, associate professor of anatomy, University of Wisconsin Medical School, Madison

Tropical Diseases

M. Fernan-Nunez, professor of pathology and bacteriology and associate professor of public health, Marquette University School of Medicine, Milwaukee

Treatment of Fractures of Forearm, Hip, Os Calcis and Ankle Joint

J. O. Dieterle, Milwaukee

Prevention of Deformity

Wisconsin Rheumatism Association

Pyloric Stenosis

A. A. Schaefer, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee; and H. W. Hefke, Milwaukee

Radiological Technic Demonstrations

Wisconsin Anti-Tuberculosis Association

Medical Literature For Loan

Gladys Ramsey, Librarian, Medical Library Service, Madison

Automobile Drivers Clinic

Wisconsin Motor Vehicle Department, Madison

Accurate Reporting of Births

State of Wisconsin Board of Health, Madison

Spread and Control of Tularemia

American Medical Association, Chicago

Pathology of Tularemia

American Medical Association, Chicago

Diseases Transmitted From Animals to Man

American Medical Association, Chicago

Botulism

American Medical Association, Chicago

Hearing Aids, Their Use and How They Work

Council on Physical Therapy, American Medical Association, Chicago

Chemistry of the Gastric Antacids

Chemical Laboratory, American Medical Association, Chicago

Chemistry of Vitamin K and Synthetic Hormones

Chemical Laboratory, American Medical Association, Chicago

Endocrine Regulation of Growth

W. O. Thompson, associate professor of medicine, University of Illinois College of Medicine, Chicago; and N. J. Heckel, Chicago; and Lieutenant R. P. Morris, Chicago

Degenerative and Pathologic Changes in Lumbosacral Intervertebral Disks

R. K. Ghormley, professor of orthopedic surgery, University of Minnesota Graduate School, Rochester; and M. B. Coventry, Rochester

Kraurosis Vulvae and Allied Affections

L. M. Randall, associate professor of obstetrics and gynecology, University of Minnesota Graduate School, Rochester; and M. C. Piper, assistant professor of medicine, University of Minnesota Graduate School; and L. A. Brunsting, assistant professor of dermatology and syphilology, University of Minnesota Graduate School, Rochester

Use of Fascia Lata in Repair of Hernias

James C. Masson, professor of surgery, University of Minnesota Graduate School, Rochester

Diagnosis of Addison's Disease

E. J. Kepler, associate professor of medicine, University of Minnesota Graduate School, Rochester; and M. H. Power, Ph. D., and F. J. Robinson, Rochester

Some Relationships of the Thyroid and Pituitary Glands to Iodine Metabolism

A. S. Chapman, Rochester; and S. F. Haines, associate professor of medicine, University of Minnesota Graduate School, Rochester

Wisconsin Radiological Society

Diseases of Gynecological System

Arnold S. Jackson, Jackson Clinic, Madison

Rationale of Bile Salt Therapy

A. C. Ivy, professor of physiology and professor of pharmacy, Northwestern University Medical School, Chicago

Obstetrical Hemorrhage

F. H. Falls, professor of obstetrics and gynecology, University of Illinois College of Medicine, Chicago

Medical Treatment of Civilian Gas Warfare Casualties

E. L. Belknap, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee; and A. R. Curreri, assistant professor of surgery, University of Wisconsin Medical School, Madison

Cancer and the Women's Field Army

Wisconsin Division, Women's Field Army

Vocational Training of the Blind

Mr. R. E. Long, Superintendent, School for the Blind, Janesville

House of Delegates of American Medical Association Meets in Chicago, June 7-9

BECAUSE of wartime conditions, the 1943 annual session of the American Medical Association was limited to a meeting of the delegates and to two general meetings which were held at the Palmer House, Chicago, from June 7 to 9 inclusive. Attendance of the House of Delegates included representatives from every state and from the territorial areas of the United States except Alaska, the Philippine Islands, the Panama Canal Zone and Puerto Rico.

Election of Officers

H. L. KRETSCHMER

Herman Louis Kretschmer of Chicago was elected president-elect of the American Medical Association by unanimous action of the House of Delegates. Dr. Kretschmer was born in Chicago on April 22, 1879. He received the degree of doctor of medicine from Northwestern University Medical School in 1904, from which date he has devoted himself continuously to the advancement of his chosen profession. He has served as president of the American Board of Urology, chairman and secretary of the Section on Urology of the American Medical Association, president of the American Urological Association, president of the American Association of Genito-Urinary Surgeons and president of the Clinical Society of Genito-Urinary Surgeons. He was president of the Chicago Medical Society in 1931 and served for a number of years as a member of its council. For more than ten years he held the office of treasurer of the American Medical Association.

The 1942 president-elect, Dr. James E. Paullin, Atlanta, Georgia, was inducted into office as president. Other officers are: Dr. John W. Amesse, Denver, Colorado, vice-president; Dr. Olin West, Chicago, secretary (succeeds himself); Dr. J. J. Moore, Chicago, treasurer; Dr. H. H. Shoulders, Nashville, Tennessee, speaker (succeeds himself), and Dr. R. W. Fouts, Omaha, Nebraska, vice-speaker (succeeds himself).

Wisconsin Delegation

Wisconsin's delegation to the House of Delegates of the American Medical Association consisted of Dr. Stephen E. Gavin, Fond du Lac; Commander James C. Sargent, Milwaukee, and Dr. Joseph F. Smith, Wausau. The speaker of the House appointed Dr. Gavin to the Reference Committee on Miscellaneous Business and Commander Sargent to the Reference Committee on Executive Session.

Dr. Gavin presented a resolution, approved by the House of Delegates of the State Medical Society, requesting a study by the Council on Medical Education and Hospitals of the American Medical Association of nursing licensure requirements. This resolution, upon report of the Reference Committee on Medical Education, was not adopted.

Dr. Sargent presented a resolution requesting constituent associations and component societies to consider the establishment of some form of dues for their members in service. Upon recommendation of the Reference Committee on Miscellaneous Business, this resolution was not adopted, although appreciation of the spirit behind the resolution was expressed.

Creation of a New Council

Following the recommendation of the Reference Committee on Legislation and Public Affairs, which reviewed several resolutions on the subject, the House of Delegates voted to create a new Council on Medi-

cal Service and Public Relations, which shall have as its functions:

1. To make available facts, data and medical opinions with respect to timely and adequate rendition of medical care to the American people.

2. To inform the constituent associations and component societies of proposed changes affecting medical care in the nations.

3. To inform constituent associations and component societies regarding the activities of the Council.

4. To investigate matters pertaining to the economic, social and similar aspects of medical care for all the people.

5. To study and suggest means for the distribution of medical services to the public consistent with the principles adopted by the House of Delegates.

6. To develop and assist committees on medical service and public relations originating within the constituent associations and component societies of the American Medical Association.

INDIVIDUAL AND PARTNERSHIP FEDERAL INCOME TAX CALENDAR

July 1, 1943, to March 15, 1944

1943

July 1	Employer starts withholding from wages at new 20 per cent rate. Victory tax withholding discontinued.
July 31	Due date of employer's return of Victory tax withheld during second quarter of 1943. Tax payable with return.
September 15	Due date of declaration by individuals of estimated tax for 1943 and one-half of the estimated tax payable.
October 31	Due date of employer's return of tax withheld during third quarter of 1943. Tax payable on this date.
December 15	Due date of second one-half of estimated 1943 tax of individuals.

1944

January 31	Due date of employer's return of tax withheld during last quarter of 1943. Tax payable on this date.
March 15	1. Due date of individual income tax return for 1943. Any excess of tax shown on this return of amounts withheld and paid in 1943 must be paid on this date. 2. Due date of certain additions to 1943 tax. (In reality one-half of the unforgiven portion of 1942 taxes.) 3. Due date of declaration of estimated tax for 1944. One-fourth of estimated tax payable on this date. (Precise filing and other requirements after March 15, 1944, not yet available.)

Some Pointers on 1943 Federal Income Tax Amendments

THE recently enacted "Current Tax Payment Act of 1943" is of immediate significance to all physicians in their dual capacities as taxpayers and employers. The points suggested below are to be read in connection with the calendar in the box above, since it is impossible to treat in detail in this *Journal* legislation of such complexity.

1. As of July 1, 1943, Victory tax withholding is discontinued except for payroll periods which began before and ended after June 30, but the Victory tax itself remains in effect and must be computed on the 1943 final income tax return filed by March 15, 1944.

2. By now every physician in active practice who has been withholding the Victory tax or a social security tax should have received a letter from the office of the Collector of Internal Revenue at Milwaukee enclosing one or more Forms W–4. The latter is the employe's withholding exemption certificate, and it is to be prepared and returned to the employer promptly by each employe *before* the first date after July 1 on which compensation is due him.

The amount of tax to be withheld will be based on the information given on the withholding certificate. The physician can determine how much is to be withheld in the case

of each employe, including salaried physicians, by turning to the tables contained on pages 6–11 of Circular WT, which should have been enclosed with the letter from the Collector referred to above. These tables are based on variations in payroll periods and dependency status, are self explanatory, and are not simplified or summarized here because of their number and length.

3. A physician who is a member of a partnership of two or more practicing physicians, or who practices alone, does *not* withhold any part of his own compensation from fees whenever he receives it, as is done in the case of his employes. His withholding in effect will be quarterly beginning September 15, 1943, at which time he can credit in full against his 1943 tax the installments paid in March and June of this year. (See Calendar above.) The withholding provisions apply to ordinary salaries, bonuses and payments other than in cash as, for example, in war bonds.

4. Despite the amount of talk and confusion about "forgiveness" of taxes, the effect of the 1943 Act will be substantially to increase the taxes due from professional men as a group. Forgiveness of the 1942 tax in the case of individuals earning a net income of $3,000 and upward a year will not reach 75 per cent in many instances, and you must not anticipate a reduction in your gross federal tax liability but, in most cases, a substantial increase, probably averaging about 30 per cent for the years 1943 and 1944 combined, assuming no changes in rates. A great deal will depend on whether your 1943 federal income tax is higher or lower than that for 1942. It is likely that rates will be increased before the end of 1943.

5. Note that on March 15, 1944, you may have *four* federal taxes to pay: (1) any balance of the 1943 income tax; (2) any balance of the 1943 Victory tax; (3) one-half of any unforgiven balance of the 1942 income tax; (4) one-fourth of the estimated 1944 income tax.

6. In your own case, and in the case of your office, have your office manager or secretary make notations on the office calendar of the dates shown on the tax calendar above. *You must not miss even one of these dates.*

7. Finally, you cannot expect, unless your situation is an extremely simple one, to handle the complicated returns and computations required by the various federal tax laws without professional assistance. You will save yourself time, needless worries, and money by seeing your attorney or a competent tax accountant.

THE SOCIETY DOES NOT ENDORSE

No endorsement or approval is given by the State Medical Society to individual insurance companies, collection agencies, or other firms or associations other than the endorsement that is inherent in the acceptance of advertising for insertion in *The Wisconsin Medical Journal.* The claims of endorsement made by those representing others than advertisers are unfounded.

It has long been an established policy of the Society not to endorse any individual company, association, agency or commercial endeavor of any description. However, the Society has for many years made available to its members, on their request, certain factual information concerning collection agencies, insurance companies, and similar organizations. An extensive library of information is maintained in the Society's office as a basis for making suggestions to members who indicate that they would like to have detailed information for their personal use and guidance.

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. E. S. Schmidt, Green Bay, President
Mrs. H. E. Twohig, Fond du Lac, President-Elect
Mrs. R. B. Dryer, Poynette, Vice-President
Mrs. R. M. Kurten, Racine, Recording Secretary
Mrs. L. D. Quigley, Green Bay, Corresponding Secretary
Mrs. Charles Fidler, Milwaukee, Treasurer
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Mrs. L. V. Sprague, Madison
Circulation of Bulletin (special committee)—
Mrs. W. A. Wagner, Oshkosh
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Mrs. A. J. McCarey, Green Bay

Fifteenth Annual Convention of Auxiliary to Be Held in Milwaukee

Dear Auxiliary Member:

On September 12–13–14, the Woman's Auxiliary to the Medical Society of Milwaukee County will again be hostess to the state convention. Despite food rationing and busy wartime schedules, we are planning your convention in keeping with the traditions of former years. The management of the Hotel Schroeder has assured us that although variety in menus may be curtailed, food will be adequate. However, room registrations are at a maximum; therefore, we suggest that you make your plans now to attend the convention and make your room reservations early.

All business meetings and social gatherings will be held at the Hotel Schroeder. Our president, Mrs. E. S. Schmidt, will preside at the preconvention session of the Board of Directors on Sunday evening and at the business meetings on Monday and Tuesday mornings. Because of the death of her husband and her own ill health, Mrs. Layton, president-elect, who would have directed the postconvention board meeting on Tuesday noon, has resigned. This vacancy will be filled by the Executive Board. Plans for luncheons and entertainment on Monday and Tuesday afternoons will be announced later.

Mrs. Eben J. Carey, Milwaukee
President, National Auxiliary.

We are signally honored this year in having as our guest Mrs. Eben J. Carey, past-president of the State and Milwaukee County Auxiliaries, and now president of the National Auxiliary. Plans for a reception in her honor Monday evening are being formulated.

Sociability, geniality, good fellowship and friendship, requisites of a successful convention, are not rationed. Therefore, if you will begin now to "scheme" ways and means to make it possible for your busy and tired husband to attend the annual meeting, we will do our utmost to make your stay interesting, restful and profitable. All doctors' wives are welcome, whether or not they are Auxiliary members. We are looking forward to seeing you in September.

Very sincerely yours,
MRS. HARRY O. ZURHEIDE
Convention Chairman

Report of National Auxiliary Meeting

Drake Hotel, Chicago, June 7-9, 1943

By MRS. E. S. SCHMIDT
Green Bay

Mrs. E. S. Schmidt, Green Bay
President, State Auxiliary

THIRTY-SEVEN national board members, eighty-six accredited delegates, twelve alternates, twenty-four members and nine guests—a total of 169 women—were registered this year at the annual meeting of the Woman's Auxiliary to the American Medical Association.

The preconvention meeting of the Board of Directors was held on Monday morning, adjourning at 12:30 p. m. to the Gold Coast Room, where a luncheon was held in honor of the past-presidents of the Auxiliary. Mrs. M. A. Nix, president of the Illinois State Auxiliary, announced that this year the Woman's Auxiliary had attained its majority. In celebration of the twenty-first anniversary of the founding of the organization, Mrs. Nix lit twenty-one tapers, one for each past-president as her name was called. The tapers twinkling in a setting of beautiful flowers were a fitting tribute to the capable builders of our Auxiliary.

As guest speaker, Dr. Frank P. Hammond, chairman of the advisory committee to the Woman's Auxiliary to the Illinois State Medical Society, chose as his subject "Doctors' Ladies, Medicine's Strongest Ally."

After the luncheon, the opening meeting of the House of Delegates was held in the Grand Ballroom, with Mrs. Frank N. Haggard presiding. In her address, Mrs. Haggard, national president of the Auxiliary, named as one of the myriad changes wrought by war the waiving of the national convention. In its place, a two-day business

session of the House of Delegates was held to effect changes in office and to dispose of necessary business. While reports of officers and committee chairmen were being given, Mrs. Dillinger, *Hygeia* chairman, reported two Wisconsin counties, Kenosha and Rock, as oversubscribing their quota.

According to the report of the organization chairman, thirty-eight states and the District of Columbia now have state auxiliaries, with a total paid membership of 25,127.

This first session was followed by a delightful tea honoring Mrs. Frank N. Haggard, president, and Mrs. Eben J. Carey, president-elect.

Reports of the state presidents, which were given at the second business meeting on Tuesday, reflected many phases of endeavor in national and state problems. With our keynote, "Health for Victory," the advancement of health education has been emphasized in every state. Countless hours spent in war activities were reported by the presidents. Much interest was shown in the excellent work of the Doctors' Aide Corps of Atlanta, Georgia. An outline of this project appeared in the December issue of the *Bulletin*, official publication of the Auxiliary.

A luncheon honoring Mrs. Haggard was also held on Tuesday, and guest speakers included Brigadier General Fred Rankin, president of the American Medical Association; Dr. James E. Paullin, president-elect; and Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*. Dr. Frank N. Haggard of San Antonio, Texas, and Dr. Eben J. Carey of Milwaukee were called upon for informal talks.

During the afternoon session the highlight of interest, especially to the Wisconsin delegates, was the installation of Mrs. Eben J. Carey of Milwaukee as president of the national Auxiliary. A corsage of orchids from the Milwaukee County Auxiliary and a bouquet of yellow roses from the Woman's Auxiliary to the State Medical Society were offered to the new president with the felicitations of the following delegates and alternates in attendance from Wisconsin:

Mrs. E. F. Barta, Milwaukee
Mrs. P. B. Blanchard, Cedarburg
Mrs. Charles Fidler, Milwaukee
Mrs. O. W. Friske, Beloit
Mrs. M. H. Fuller, Green Bay
Mrs. H. J. Heeb, Milwaukee
Mrs. O. J. Hurth, Cedarburg
Mrs. F. R. Janney, Wauwatosa
Mrs. D. H. Jeffers, Lake Geneva
Mrs. L. H. Lokvam, Kenosha
Mrs. J. R. Minahan, Wauwatosa
Mrs. E. F. Peterson, Wauwatosa
Mrs. A. M. Rauch, Kenosha
Mrs. H. O. Zurheide, Milwaukee

National Board officers present from Wisconsin were Mrs. R. E. Fitzgerald, Wauwatosa, parliamentarian and past-president of the national Auxiliary, and Mrs. E. S. Schmidt, Green Bay, president of the state Auxiliary.

On Tuesday evening many of our members were in attendance when Dr. James E. Paullin, Atlanta, Georgia, was installed as president of the American Medical Association. This function took place in the Grand Ballroom of the Palmer House.

At the Auxiliary Board of Directors meeting on Wednesday morning, Mrs. Carey honored two Wisconsin women by appointment to the national Board. Mrs. Charles Fidler of Milwaukee was named corresponding secretary, and Mrs. O. W. Friske of Beloit was appointed program chairman.

Dr. James P. Simonds, professor of pathology, Northwestern University Medical School, gave an interesting talk on "The Effect of War on Medicine."

Mrs. Carey's outline of plans for the coming year brought to a conclusion at noon on Wednesday a very successful meeting.

Mrs. Henry E. Twohig of Fond du Lac has been elected to fill the vacancy of president-elect of the Woman's Auxiliary to the State Medical Society, occasioned by the resignation of Mrs. O. M. Layton, Fond du Lac.

Mrs. Twohig, a former State Board member and former president of her county auxiliary, is well known in Auxiliary circles. She was elected at a meeting of the Executive Committee held on June 9.

County Auxiliary Proceedings

Fond du Lac

Concluding their spring activities, members of the Woman's' Auxiliary to the Fond du Lac County Medical Society met for tea on May 27 at the home of Mrs. H. R. Sharpe, Fond du Lac. Mrs. Nora McGauley and Mrs. E. V. Smith, Jr. presided at the tea table.

Mrs. L. J. La Motte entertained with a group of vocal solos, accompanied by Mrs. Robert Mabie. A review of Paul Gallico's book, "The Snow Goose," was given by Mrs. E. L. Watson of Ripon.

Assisting hostesses were Mmes. J. C. Devine, W. J. Waldschmidt, S. A. Theisen and D. J. Twohig, Jr., all of Fond du Lac.

Kenosha

On May 11, a meeting of the Kenosha County Auxiliary was held at the home of Mrs. L. M. Rauen, Kenosha. Mrs. Theodore Sokow, Mrs. W. C. Stewart and Mrs. Alexander Schlapik assisted the hostess.

At the business meeting, reports were given by chairmen of standing committees. Mrs. Rauen, public relations chairman, described a health exhibit on display at a local museum. Mrs. E. F. Andre told of the work of the Girl Scouts, and Mrs. Schlapik reported on USO activities during the month. As the April contribution of this auxiliary, a turkey was roasted for the USO by Mrs. Schlapik, and on May 21 a rummage sale added $87 to the group's philanthropic fund. Mrs. Schlapik was chairman of the sale and was assisted by Mmes. A. J. Randall, W. C. Kleinpell and H. A. Robinson. Mrs. A. L. Mayfield is chairman of the committee on medical legislation of the Kenosha Auxiliary.

"Gardening As a Hobby" was the subject of an informal talk given by Mrs. C. H. Gephart during the social program. After the business meeting and program, Mrs. C. C. Davin presided at the refreshment table.

Polk

Members of the Woman's Auxiliary to the Polk County Medical Society joined their husbands for dinner at "Little Bit of Sweden" at Taylors Falls on Thursday, May 27. They adjourned to the home of Mrs. C. A. Kelly for their business session.

Racine

Mrs. W. E. Buckley, Racine, was hostess to members of the Racine County Medical Auxiliary on April 12. Assisting hostesses were officers and committee chairmen. Mrs. R. M. Kurten and Mrs. F. C. Christensen poured at a tea table made attractive with spring flowers.

Honored guest of the afternoon was Mrs. E. S. Schmidt of Green Bay, state president, who talked to the group on medical progress in the present war. She stressed the necessity of health preservation and urged participation in the drive to sell and purchase bonds and stamps.

The regular monthly meeting of the Woman's Auxiliary to the Racine County Medical Society was held on May 10 at St. Mary's Hospital, Racine. A talk on mental hygiene was given by Dr. Elizabeth Kane of the Bureau of Maternal and Child Health, State Board of Health.

Society Proceedings

Brown—Kewaunee—Door

Twenty members of the Brown–Kewaunee–Door County Medical Society met at the Beaumont Hotel, Green Bay, on June 10 at 6:30 p. m. Following dinner, there was a prolonged discussion on various matters related to the interests of the society in regard to the administration of the Brown County Pension Department, and a committee was appointed to appear before the County Board of Brown County on behalf of the County Medical Society during the summer months.

Dane

Because of the various difficulties arising out of the present war situation, the Board of Trustees of the Dane County Medical Society canceled the annual June picnic meeting. The next meeting, which will be held in September, may be combined with a golf tournament.

Dodge

The last meeting of the Dodge County Medical Society for the year 1942–43 was held Thursday evening, May 27, at the Hotel Rogers, Beaver Dam. The business meeting was preceded by a dinner party for the members and their wives.

Douglas

Speaking on "Pyloric Stenosis," Dr. William Coventry of Duluth, Minnesota, was a guest of the Douglas County Medical Society at its dinner meeting at Hotel Superior, Superior, on June 2.

Fond du Lac

Dr. O. S. Orth of the department of pharmacology of the University of Wisconsin Medical School was speaker at a dinner meeting of the Fond du Lac County Medical Society held at 6:30 p. m., Thursday,

May 20, at the Hotel Retlaw, Fond du Lac. He treated his subject, "Gas Warfare," from a professional and scientific point of view and discussed the action and treatment of the different gases now used in warfare.

Green Lake—Waushara

The Green Lake and Waushara County Medical Society met at the Berlin Memorial Hospital, Berlin, Thursday evening, May 20, at 6:30. Dr. Karver L. Puestow of the University of Wisconsin Medical School, Madison, spoke on "Gastroscopy." Following his talk, a medical motion picture on peptic ulcer was shown. This was the last meeting of the society until the fall of the year.

Jefferson

Following the entrance of Dr. Oscar H. Hanson, Fort Atkinson, secretary of the Jefferson County Medical Society, into the armed services of the United States, Dr. Otto F. Dierker, Watertown, is serving as acting secretary of the society.

Racine

Members of the Racine County Medical Society and the medical staff of Sunny Rest Sanatorium, Racine, held their joint annual dinner at the sanatorium on Wednesday, June 16.

After dinner, the following scientific program was presented:

Virus Pneumonia—Dr. Mary Broadbent of the medical staff of the Wisconsin Anti-Tuberculosis Association

Myocarditis vs. Tuberculosis—Dr. Albert M. Lindner, Racine

Silicotuberculosis — Dr. William C. Hanson, Racine

Tuberculosis Suspected—Dr. Jacob F. Henken and Dr. William R. Kreul, Racine

Physician guests at the dinner, in addition to members of the society and the staff and board of trustees of the sanatorium, were Dr. Florence MacInnis, head of the tuberculosis division of the Health Department of the City of Milwaukee, Dr. Oscar Lotz, executive secretary of the Wisconsin Anti-Tuberculosis Association, Dr. Timothy L. Harrington, consultant of the Association, and Dr. Arthur A. Pleyte of the medical staff of the Association, all of Milwaukee. Several members of the Kenosha County Medical Society also were present.

Rock

The second of a series of discussions on various diseases noted in the cities of Janesville and Beloit made up the program presented at the May dinner meeting of the Rock County Medical Society at the Hotel Hilton, Beloit, on May 25 at 6:30 p. m. The program, a symposium and survey of gall bladder surgery in Mercy Hospital, Janesville, and the Beloit Municipal Hospital, Beloit, from 1929 to 1934, was arranged by Dr. Wayne A. Munn, Janesville, Dr. Herbert A. Raube, Beloit, and Dr. Thomas H. Flarity, Beloit. The discussion was led by Dr. Erwin R. Schmidt, professor of surgery at the University of Wisconsin Medical School, Madison.

Shawano

A film entitled "Burns in Wartime with Treatment" was shown at the May meeting of the Shawano County Medical Society at the Shawano Hospital on Friday, May 21. A business meeting was held.

Trempealeau—Jackson—Buffalo

The Trempealeau–Jackson–Buffalo County Medical Society met at the MacCornack Clinic, Whitehall, at 8:00 p. m. on June 17. Eighteen members attended.

Lieutenant Colonel William T. Pugh, Major Edward Gall, Major O. A. Kilpatrick, and Captain B. C. Dockendorff, medical officers from the Station Hospital, Camp McCoy, Sparta, participated in a symposium on "Peptic Ulcer." The medical, surgical, physiologic, pathologic and psychiatric aspects of the disease were thoroughly discussed.

Winnebago

A dinner meeting of the Winnebago County Medical Society was held Thursday evening at 6:30 p. m. at the Athearn Hotel, Oshkosh. Dr. Frederick W. Madison of the Marquette University School of Medicine, Milwaukee, gave an instructive talk on "Differential Diagnosis of Abdominal Diseases."

Dr. Gerhard R. Anderson, Neenah, formerly vice-president, assumed the office of president at this meeting to succeed Dr. Vincent G. Springer, who has moved from Omro to Illinois. Dr. William Wagner, Oshkosh, was elected vice-president to fill the vacancy in that office.

SOCIETY RECORDS

New Members

J. C. Rodick, St. Mary's Hospital, Racine.

J. A. Bocella, 2200 West Kilbourn Avenue, Milwaukee.

D. W. Melick, Wisconsin General Hospital, Madison.

Robert E. Terry, Cuba City.

Changes in Address

M. P. Ohlsen, Milwaukee, to 1700 South 60th Street, West Allis.

F. J. Mellencamp, Milwaukee, to 424 Ninth Street, Cambridge, Ohio.

Ruth C. Foster, Madison, to 6662 Hillandale Road, Apt. 2, Chevy Chase, Maryland.

News Items and Personals

The Committee on Mental Hygiene and Institutional Care, in accordance with recommendations of the committee and approved by the House of Delegates, is visiting a number of county asylums and hospitals.

Shown in the picture from left to right are *Walter J. Urben*, M. D., Mendota, of the Department of Public Welfare, *Henry H. Christofferson*, M. D., Colby, chairman of the Committee on Mental Hygiene and Institutional Care, and *Byron J. Hughes*, M. D., Winnebago.

—△—

Dr. Charles P. Kauth, Port Washington, was elected president of the staff of St. Alphonsus Hospital, Port Washington, and *Dr. Porter B. Blanchard*, Cedarburg, secretary. The past-president, Dr. T. D. Elbe, Thiensville, presided as toastmaster at the annual banquet held that evening.

—△—

At a recent reorganization of the Kaukauna board of health, *Dr. John Hogan* was reappointed city health officer.

—△—

On May 21, *Dr. Michael R. Wilkinson*, Oconomowoc, observed the fiftieth anniversary of his practice of medicine. An 1893 graduate of the Northwestern University Medical School, Chicago, he began his career as a physician in Oconomowoc shortly after his graduation and, since that time, has taken an active part not only in the medical activities of the city but in civic affairs as well. His practice of medicine has been continuous except for the period in World War I when he was an officer in the medical corps of the United States Army.

Associated with him in practice are three sons: *Dr. J. Francis, Dr. John D.*, and *Dr. Donald C. Wilkinson*. A fourth physician-son, *Captain Philip Wilkinson*, is stationed in Australia.

—△—

Addressing the Rotarians of Kaukauna at their weekly luncheon meeting on June 1, *Dr. Raymond H. Quade*, Neenah, spoke on nervous disorders. Briefly describing the various kinds of unbalanced personalities, he defined a well balanced person as "one who is free of symptoms, is unhampered by mental conflict, and has a satisfactory working capacity and the ability to love someone other than himself."

—△—

At a meeting of the De Pere board of health on Thursday, May 27, *Dr. James P. Lenfestey* was reelected health officer of that city.

—△—

"The Role of the Doctor in Wartime" was the topic of the address presented by *Dr. Robert E. Fitzgerald*, Milwaukee, state chairman of the Procurement and Assignment Service, at a dinner meeting of the Milwaukee Round Table on Wednesday, May 26, at the Wisconsin Hotel, Milwaukee.

—△—

Dr. Emmet T. Ackerman, Gays Mills, spent the second week in May at the Mayo Clinic doing postgraduate work. Dr. Ackerman's observations were principally concerned with the latest developments in surgery and obstetrics.

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The following Manitowoc physicians were elected to the staff of the Holy Family Hospital, Manitowoc, at its annual election of officers on Thursday, June 3:

President—*Dr. Nelson A. Bonner*
Vice-president—*Dr. Russell G. Strong*
Secretary—*Dr. Theodore A. Teitgen*

—△—

Dr. Francis P. Daly, Chippewa Falls, deputy state health officer, spoke at a hospital rally held in Barron on Thursday, May 13. A project for a municipally owned hospital has been undertaken in that city.

—△—

Because the recruiting of a large number of Appleton physicians by the Army and Navy has increased the demands on his time, *Dr. George T. Hegner*, Appleton, found it necessary to resign from the board of education of that city. He had served as a member since 1933.

—△—

On Tuesday, June 8, *Dr. Norman C. Erdman*, Manitowoc, addressed members of the Manitowoc Kiwanis Club. Speaking on the sulpha drugs, he said that although this potent chemical product was first discovered by an obscure German scientist as long ago as 1908, its use did not become general

until about 1936, when American specialists went to Europe, brought the drug back to America, and began experimenting with it. He discussed its extensive use in the present war.

Dr. Theodore Teitgen, Manitowoc, was named a delegate from the club to the Milwaukee conference to be held August 1 and 2.

—△—

Dr. Robert L. MacCornack and *Dr. Neil S. Simons* were re-elected members of the board of directors of the Whitehall Community Hospital, Whitehall, at the twenty-sixth annual dinner meeting of the hospital directors and trustees on Monday, June 7.

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On May 22, *Dr. Bertha E. Reynolds*, Avoca, spent her seventy-fifth birthday anniversary at work. Despite the fact that she is at an age when many persons consider retirement, her activities have become more extensive than ever as a result of the entrance into the service of the armed forces of other nearby physicians.

During her seventy-fifth year, Dr. Reynolds purchased and remodeled a house in Avoca which is now used as a combination office and residence.

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American Neuro-Psychiatric Society

The annual dinner meeting of the American Neuro-Psychiatric Society was held at the University Club, Milwaukee, on Thursday, May 27, at 6:00 p. m. The program consisted of reports by members on the recent meetings of the American Psychiatric Association and the American Neurological Association.

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The Wisconsin Academy of Surgery

The Wisconsin Academy of Surgery held its annual spring meeting in Madison on Wednesday, May 19, with about thirty-five members attending. While the Academy holds two meetings a year in Milwaukee and two in other cities in Wisconsin, this was the first time that Madison had been chosen as the site of a meeting.

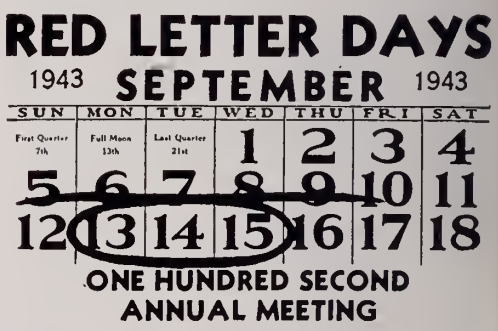
The all-day program was composed of papers by twelve members of the staff of the Jackson Clinic, Madison. In addition, visiting members took part in discussions of hernia, cancer, burns, "sulfa" drugs, skull fractures, and varicose veins.

COMING EVENTS

The Association of Military Surgeons of the United States

The Association of Military Surgeons of the United States will hold its Fifty-first Annual Convention at the Bellevue–Stratford Hotel, Philadelphia, from October 21 to 23, inclusive. The three-day convention will assemble physicians from all the current war fronts where United States forces are fighting and from the great base hospitals where rehabilitation of the wounded is in progress. These physicians will bring with them information on the latest technics of wartime medicine and surgery. Numerous forum lectures, practical demonstrations, moving pictures, and teaching panels are planned.

Honorary chairman of the convention this year is Rear Admiral Ross T. McIntire, Surgeon General of the Navy. The general chairman is Captain Joseph A. Biello of the medical corps of the United States Navy, who is District Medical Officer of the Fourth Naval District.



American Board of Obstetrics and Gynecology, Inc.

Applications for the 1944 examinations of the American Board of Obstetrics and Gynecology, Inc., are being received at the office of the Secretary, Dr. Paul Titus, 1015 Highland Building, Pittsburgh, Pennsylvania. Booklets of information regarding Board requirements and examinations, together with application forms, will be sent upon request. All applications for the year 1944 must be in the office of the secretary not later than November 15, 1943, ninety days in advance of the examination date for Part I.

Candidates are required to take both Part I and Part II examinations. The Part I examination consists of the written paper and the submission of twenty-five case history abstracts and will be conducted on Saturday, February 12, 1944. This examination will be arranged so that the candidate may take it at or near his place of residence. Upon the successful completion of the Part I examination, candidates are eligible for the Part II examination, which consists of a pathology and an oral examination. This is given at the annual meeting of the Board once each year, the time and place of which will be announced later.

The Office of the Surgeon General of the United States Army has issued instructions that men in service who are eligible for Board examinations should be encouraged to apply and that they request orders to "detached duty" for the purpose of taking the examinations whenever possible.

American Congress of Physical Therapy

The American Congress of Physical Therapy will hold its twenty-second annual scientific and clinical session on September 8 to 11, inclusive, at the

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Palmer House, Chicago. The annual instruction course will be held from 8:00 to 10:30 a. m. daily and also from 1:00 to 2:00 p. m. during the days of September 8, 9, and 10. The course will include a round-table discussion group from 9:00 to 10:30 a. m. on Thursday, September 9. The scientific and clinical sessions will be given on the remaining portions of these days and evenings.

A feature will be an hour's demonstration showing technic and will be given on September 8, 9, and 10 from 5:00 to 6:00 p. m.

All of these sessions will be open to members of the medical profession and their qualified aids. For information concerning the instruction course and program of the convention proper, address the American Congress of Physical Therapy, 30 North Michigan Avenue, Chicago.

BIRTHS

A son, Arthur Gerald, to Lieutenant and Mrs. Kenneth A. Seifert, Ashland, on May 29.

A daughter, Jeanne Marie, to Dr. and Mrs. William R. Marquis, Waunakee, on May 27.

A daughter to Dr. and Mrs. C. L. Ingwell, Deerfield, on May 28.

A son to Dr. and Mrs. Marvin F. Stricker, Middleton, on June 19.

DEATHS

Dr. John Mayo Conley, 69, who practiced medicine in Oshkosh for forty-six years, died June 7 following an illness which had first manifested itself last December. He was a specialist in psychiatry.

He was born at Carlinville, Illinois, in 1873. After completing preparatory courses in the college of liberal arts of the University of Wyoming and Northwestern University, he was graduated from the Northwestern University Medical School, Chicago, in 1897. With the exception of the period between June, 1917, and February, 1919, when he served in the medical corps of the United States Army in World War I, he practiced medicine in Oshkosh continuously from the time of his graduation to the time of his death.

Dr. Conley served as health officer for the city of Oshkosh for a number of years. Since 1908 he had been medical director of the Wisconsin National Life Insurance Company, of which he was one of the founders.

At the time of his death, he was a member of the Winnebago County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by a daughter and a son.

Dr. Henry C. McQuillin, 70, died May 25 at a hospital in Madison, the city in which he had practiced for eighteen years. He was born in Delta and was a graduate of the Physio-Medical College of Indianapolis, Indiana. He was a physician in Toledo, Ohio, before he established a practice in Madison.

Survivors, besides his widow, are one daughter, his father, one brother, and two sisters.

Dr. Carl A. Falbe, 79, a practicing physician at Richfield for many years, died Wednesday morning, June 23. A native of Friedberg, Germany, he received his medical education at the University of Berlin. He came to the United States forty-four years ago and first resided in Milwaukee, where he practiced from 1900 to 1909. After practicing in Hartford for awhile, he established a practice in Richfield, where he resided until the time of his death.

Dr. Edward Jarvis, 66, Madison, died suddenly at his home on Saturday afternoon, June 12. He had just returned from the Mayo Clinic, Rochester, and it was thought that his condition was much improved. A physician and surgeon in Chicago for many years, he gave up his profession because of ill health and made his home in Madison.

His only survivor is his widow.

Dr. Joseph P. Schlaikowski, 55, a physician at Muirdale Sanatorium, Wauwatosa, for the last twenty-three years, died Monday, June 14. A native of Milwaukee and a graduate of the Marquette University School of Medicine, he had formerly practiced in Milwaukee.

Survivors include a brother and four sisters.

Dr. Edward J. Konop, 48, a practicing physician at Sawyer since 1924, died Thursday night, June 17. His illness had extended over a period of five years.

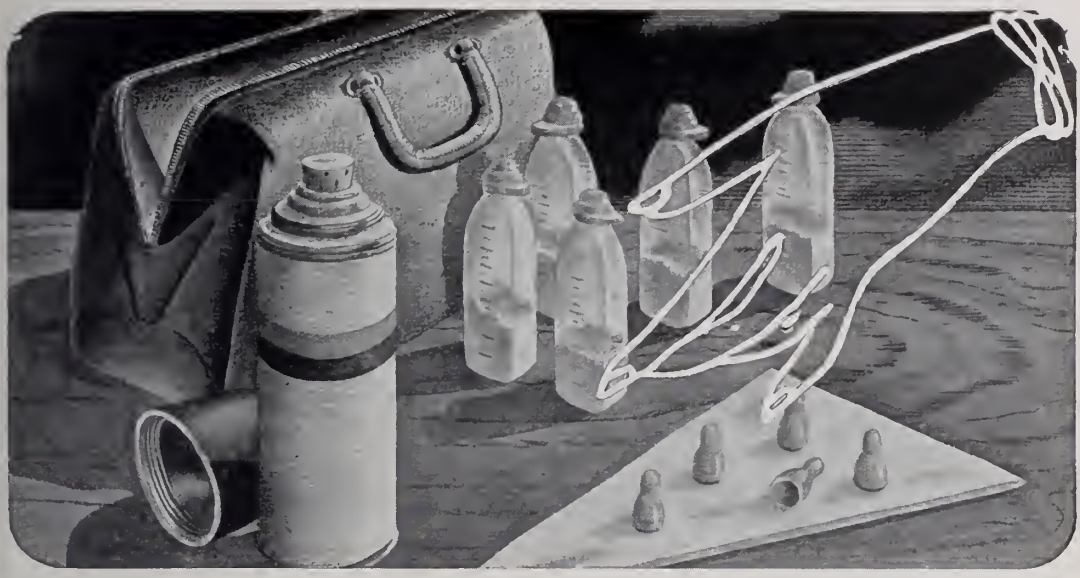
He was born at Kellnersville on July 17, 1894. Following graduation from Oshkosh State Teachers College, he taught school two years at Washburn. He enlisted in the armed forces in World War I and served overseas in France.

Dr. Konop enrolled at the Marquette University School of Medicine, Milwaukee, after the war and graduated in 1924. He interned at St. Elizabeth's Hospital in Appleton and later opened an office in Sawyer.

He was a member of the Brown–Kewaunee–Door County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Before he was taken ill, he was medical examiner for the Door County selective service board.

His widow, three children, a brother, and three sisters survive him.

Dr. Edward Hougen, 72, died June 21 as a result of a serious throat affliction, from which he had suffered for many months. He had practiced in Wisconsin Rapids for the last thirty years. His ill health had forced him to give up his practice during the fall of 1942, but, in hopes that he would eventu-



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ally be able to resume active practice, he had never discontinued his office.

He had previously practiced at Pittsville from the time of his graduation from Northwestern University Medical School in 1896 until starting his practice in Wisconsin Rapids in 1913. Manitowoc County was his birthplace. At the time of his death, he was a member of the Wood County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are three sons, two brothers, and three sisters.

The Press

Two Views

The Right Action

"The Wisconsin legislature has acted wisely this session in rejecting proposals of socialized medicine while so many of our medical men are engaged on the fighting front and others are working overtime to care for the health of workers on the home front.

"Doctors of the nation have responded nobly to the call for volunteers to work the miracles of modern medical science close behind the battle lines, thereby saving the lives of thousands of wounded soldiers.

"Older practitioners who are unable to stand up under the rigors of battle service are worked to the limit at home as they try to supply medical care for all who need it in communities depleted of doctors.

"To have taken advantage of the absence and abstraction of these men at this time by passing legislation inimical to their interests would have been a betrayal of them while they are devoting their skill and in many cases their lives to the welfare of their fellow men.

"Two of the bills defeated by votes of approximately two to one in the assembly would have established a state system of compulsory sickness insurance in one instance and would have authorized unsupervised forms of medical and hospital insurance schemes in the other.

"Competent sources estimated that the compulsory insurance plan would have required a force of 20,000 to 25,000 administrative employes, using up at least 25 per cent of the $36,000,000 to be collected annually from 2,000,000 Wisconsin citizens ostensibly for purchasing medical, hospital, and dental service. If the remaining money was not enough to pay the proposed fee schedule for doctors, they would be forced to accept payment on a lower basis.

"Certainly this is no time to impose any such plan upon the doctors of Wisconsin, nor will congress try to put over a similar scheme nationally with any greater success. Besides building a bigger bureaucracy solicitous of the citizen "from the cradle to the grave," this would be an ill-chosen and ill-timed reward for the service which our modern men of medical skill and science are rendering in this period of emergency." From the *Wisconsin State Journal*, June 1, 1943.

The Medical Society is Still Fighting Co-Operative Medicine

"The powerful lobby of the Wisconsin Medical society continues to fight against all legislation designed to aid in extending medical care and opportunity to a larger number of people.

"The Medical society will continue to blacklist any doctor in Wisconsin who gets out of the orthodox groove and becomes identified with any movement which is trying to bring a larger measure of adequate medical care to the people.

"Last week in the assembly the Medical society again defeated a bill which would have forbidden discrimination against a physician or patient because of participation in a medical co-operative.

"Similar legislation has been presented to previous sessions, and always the Medical society lobby has blocked its passage. Apparently organized medicine in Wisconsin wants to cling to its privilege to discriminate against any doctor or patient who disagrees with the society on medical care.

"The Wisconsin Medical society may have its way in a legislature which is as reactionary as the present one. However, the Medical society is storing up a lot of future troubles for itself in its stubborn fight against a medical program designed to protect the social welfare.

"Are the leaders in organized medicine in this state particularly proud of the historical opposition of the society to every move in this state to make the profession of medicine square more fully with public welfare instead of providing big fees for the doctors?

"We can recall when the Wisconsin Medical society bitterly opposed the establishment of the student infirmary at the University of Wisconsin—part of a student health program which has brought a high standard of medical care for university students.

"The members of the Dane county Medical society lobbied furiously against the infirmary measure because the plan would take some business from them.

"Reports reaching The Capital Times at the present time are to the effect that the Wisconsin Medi-

cal society is still opposed to the child health programs instituted in the public schools of the state and aided by the state board of health which provides for vaccination against disease and other medical care.

"The doctors would rather do the vaccinating in their offices with school children coming as private patients.

"The forces of organized medicine have scored another victory in the legislature in defeating the anti-discrimination bill, but it was a victory for their own selfish viewpoint and not for the public health or the public welfare.

"The Capital Times believes that the people are going to find some way to get adequate medical care at more reasonable prices than is available at present under private medicine. The medical society cannot continue to hold the clock back forever." From the *Madison Capital Times*, May 18, 1943.

An Island of Health

"Pap mongers are busily conniving for socialized medicine while a large proportion of the doctors are serving in the armed forces and unable to defend their profession. They propose medical experiments for this country, in blissful ignorance of the vast new problems which the medical profession must solve, and fortunately is solving, before there can be any assurance of a healthy America in the future. Prior to the war, medical science had succeeded in making within our continental borders a sort of island of health. Thanks to American doctors, the United States was practically rid of the most deadly maladies. Malaria, typhoid, yellow fever, tuberculosis, plague and others too numerous to mention, were either eliminated or under reassuring control. And then war came.

"Millions of men have now been shipped to the four corners of the earth. They are subject to diseases unheard of by civilians at home. Our doctors are with them, alongside of them at the battlefront, dying with them in the foxholes. It is part of their job to see that disease is kept out of the states, and that our men are kept healthy. Our war transportation system, which shuttles about the globe to all the plague spots with the regularity of interurban commuter trains, has not made the problem any simpler.

"Our doctors, with the weapons of science and research, are now attacking disease at its source, in jungle tropics and war-shattered nations. Their work should not be impeded by the provincial schemers who think that health is merely a matter of passing a law." From the *Ripon Commonwealth*, June 4, 1943.

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Trade News

Any Physician May Exhibit "When Bobby Goes to School" to the Public

Under the rules laid down by the American Academy of Pediatrics, their educational-to-the public film, "When Bobby Goes to School," may be exhibited to the public by any licensed physician in the United States.

All that is required is that he obtain the endorsement by any officer of his county medical society. Endorsement blanks for this purpose may be obtained on application to the distributor, Mead Johnson & Company, Evansville Indiana.

Such endorsement, however, is not required for showings by licensed physicians to medical groups for the purpose of familiarizing them with the message of the film in advance of public showings in the community.

"When Bobby Goes to School" is a 16-mm. sound film, free from advertising, dealing with the health appraisal of the school child, and may be borrowed without charge or obligation on application to the distributor, Mead Johnson & Company, Evansville, Indiana.

American Home Products Corporation Announces Expansion

Alvin G. Brush, chairman of American Home Products Corporation manufacturer of drugs, foods and household products, today announced an expansion in the field of biologic products through the affiliation of E. E. Bartos, Inc., of Locust Valley, N. Y., with Reichel Laboratories, Inc., American Home Products subsidiary.

The Bartos company manufactures and distributes an unique and streamlined method for determining protein allergies through intracutaneous injections. Put out in a compact kit for doctors, the Bartos System permits making tests for protein allergies at one time, and with one hypodermic needle.

Manufacture of these products will be transferred to the Reichel Laboratories at Kimberton, Pa., and will be directed there by Dr. John Reichel, head of the laboratory bearing his name and for years an outstanding figure in the biologic and scientific field.

The Bartos products will be marketed under the name of Reichel Laboratories Allergins–Bartos System. Elmer E. Bartos, founder of the system, will join the Reichel sales staff and will assist in a nationwide selling program to the medical profession.

Reichel Laboratories is one of the nation's leading producers of dried blood plasma for the nation's armed forces. It also is turning out large quantities of typhus vaccines on government orders, and is operating 100 per cent on war work.

The Bartos acquisition is the third expansion step taken by American Home Products this year as part of a long-range diversification program. On March 1, Ayerst, McKenna & Harrison Limited, leading Canadian producer of biologic and pharmaceutic products, and its American affiliate became part of American Home Products. Last month the corporation acquired the G. Washington Coffee Refining Company, pioneer in the field of instant coffee.

Squibb Adds Progesterone in Oil to Hormone Line

For the treatment of certain cases of habitual or threatened abortion, dysmenorrhea and functional bleeding, E. R. Squibb & Sons, New York, have added Progesterone in Oil to their extensive line of hormone products. This is a sterile preparation of pure crystalline progesterone in corn oil for intramuscular administration, standardized in terms of International units. One I. U. is the progestational activity of 1 mg. of the crystalline standard.

Progesterone in Oil Squibb is supplied in ampuls containing sufficient material for the withdrawal and administration of 1 cc. It is available in the following sizes:

1-cc. ampuls containing 1.0 mg. (1 I. U.) Progesterone, in boxes of 3, 12 and 25 ampuls.

1-cc. ampuls containing 2.0 mg. (2 I. U.) Progesterone, in boxes of 3, 12 and 25 ampuls.

1-cc. ampuls containing 5.0 mg. (5 I. U.) Progesterone, in boxes of 3 and 12 ampuls.

Winthrop Chemical Company Announces Appointments

Edward Dawson Davy, Dean of the School of Pharmacy, Western Reserve University, Cleveland, has been appointed Director of the Pharmaceutical

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Division of Winthrop Chemical Company, according to an announcement by Dr. Theodore G. Klumpp, president. Mr. Davy will make his headquarters at the company's plant at Rensselaer, N. Y.

For the past twenty-one years, Mr. Davy has been associated with Western Reserve, serving as Professor of Pharmaceutical Chemistry until his appointment as Dean of the School of Pharmacy in 1940.

Election of Dr. A .E. Sherndal, plant superintendent of Winthrop Chemical Company, as vice-president was announced recently by Dr. Theodore G. Klumpp, president. Long associated with the company, Dr. Sherndal recently was awarded an honorary degree of Doctor of Science by St. Lawrence University for his research work in the synthesis and manufacture of Atabrine, synthetic substitute for quinine in the treatment of malaria, entirely from raw materials available in the United States.

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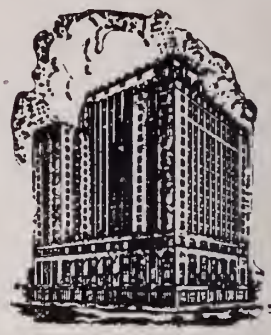

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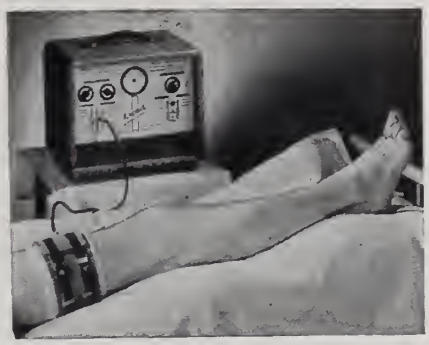

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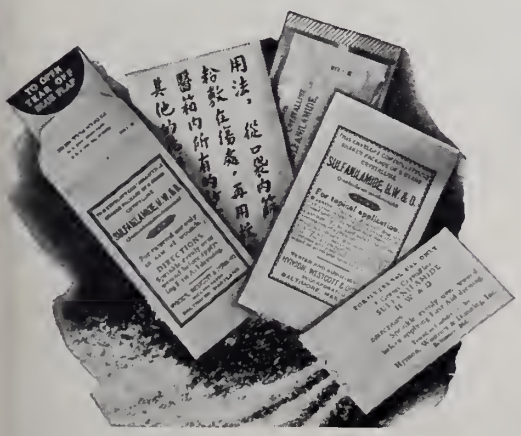

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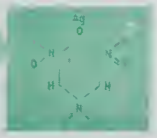

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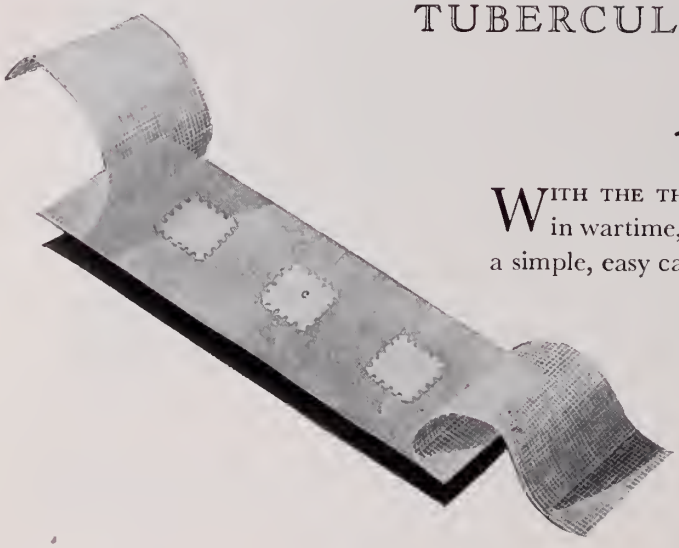

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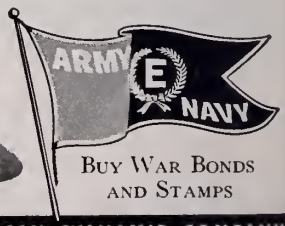

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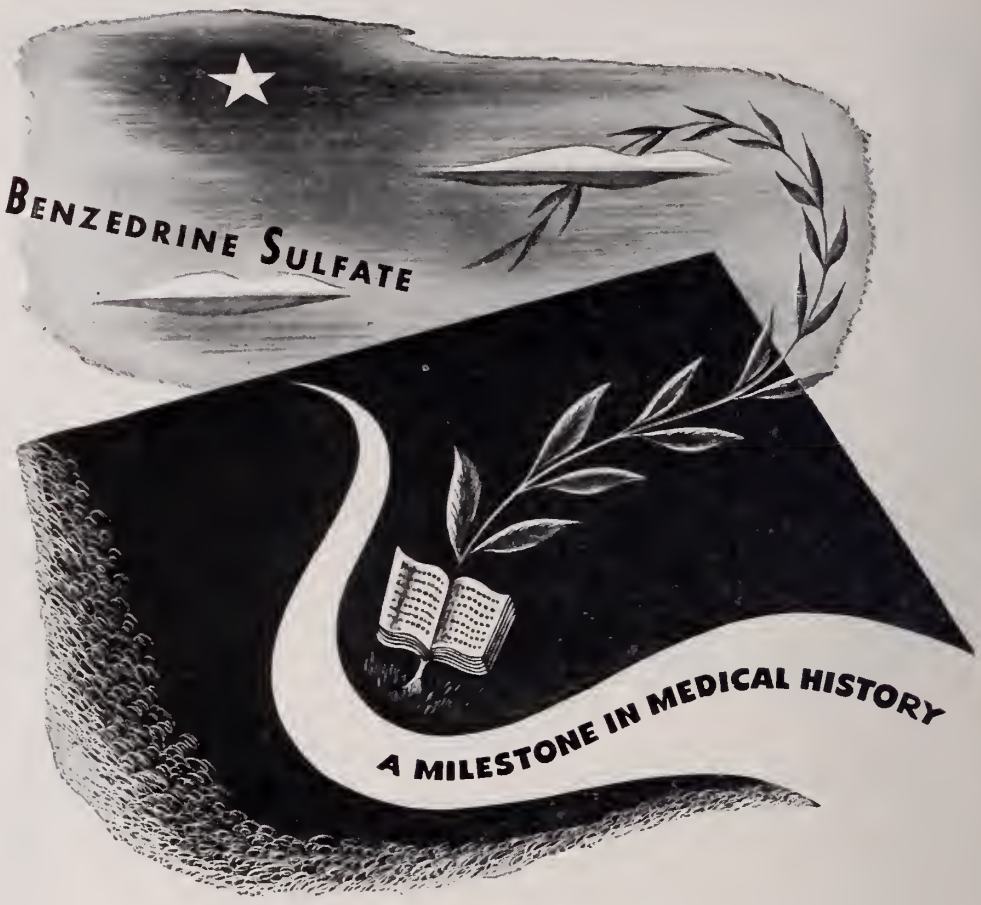

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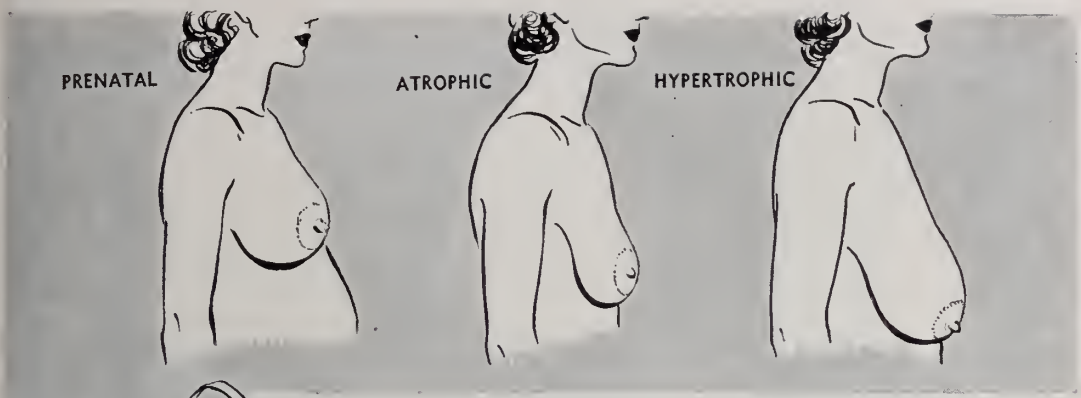

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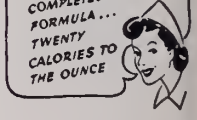

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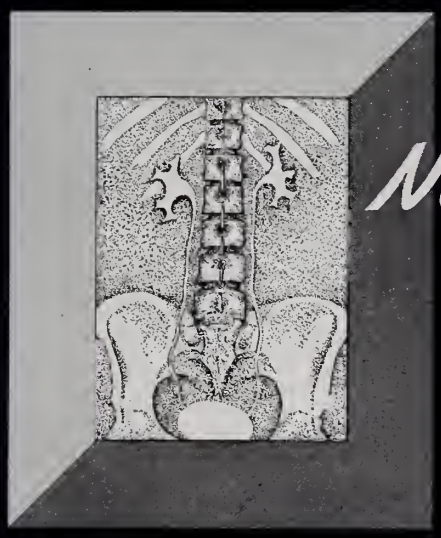

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THE WISCONSIN MEDICAL JOURNAL

VOLUME 42, NO. 8 Copyright, 1943, by The State Medical Society of Wisconsin AUGUST, 1943

The Treatment of Cardiovascular Emergencies in the Home*

By FRANCIS D. MURPHY, M. D.
Milwaukee

F. D. MURPHY

Dr. Murphy, clinical professor of medicine at Marquette University School of Medicine, Milwaukee, received his M. D. degree at the same university in 1921. He is a member of the American Board of Internal Medicine, the Central Society for Clinical Research, and the American College of Physicians.

THE proper management of acute cardiovascular emergencies constitutes one of the most serious problems in modern medicine. The frequent occurrence of such "heart attacks," as well as the dire consequences of improper treatment, gives this subject added significance. As such attacks usually occur in the home, the immediate treatment there is of special concern.

The chief role of the physician who is called first is to determine whether the patient has had a heart attack or some condition simulating it. Acute coronary thrombosis and certain abdominal disasters such as perforation of a peptic ulcer or the gall bladder may resemble each other so closely that all the skill, experience, and judgment possessed by the physician must be summoned to make the correct diagnosis. Such differentiation may be crucial; for instance, though immediate operation is the lifesaving measure for an abdominal catastrophe, such an operation would probably cause the death of the individual with a coronary thrombosis.

Regardless of his speciality, any physician may be summoned to administer the first treatment to the patient with a cardiac emergency. As it is the general practitioner who usually is called upon in such dire need, and not the heart specialist, his role is of the utmost importance.

Not all cardiac emergencies are of the violent kind, as is coronary thrombosis; many are of a more innocent nature. Nevertheless, they cause great anxiety. While I shall not discuss all of the cardiac emergencies that may arise in a general practice, I shall take up those types which are most common.

Coronary Disease

Diseases of the coronary artery may cause three distinct kinds of heart ailments: (1) coronary arteriosclerosis, which may cause angina pectoris; (2) coronary thrombosis, which causes myocardial infarction; and (3) coronary sclerosis, which leads to myocardial degeneration and failure. Angina pectoris and coronary thrombosis are two clinical conditions which may arise abruptly and constitute outstanding cardiac emergencies.

Angina Pectoris

Anginal pain is the result of a lack of oxygen in the heart muscle. The degree of coronary narrowing bears no direct relation to the intensity, frequency, or duration of the anginal attacks. Angina is a common expression of coronary disease, though it is not often classed as a cardiac emergency. The pain is not severe enough nor prolonged sufficiently to be considered critical in most instances, although it may at times be very alarming. The chief significance of angina pectoris is the emphasis that it places by contrast on coronary thrombosis.

* Presented before the One Hundred First Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1942.

Its recognition is aided by a few simple rules. The patient usually is not under 40 years of age. The pain comes following exercise, emotional disturbances, or a heavy meal. It occurs in the upper part of the sternum, radiates to the neck and down the shoulder into the arms, and causes the patient to be very apprehensive. The spell lasts from five to ten minutes and then passes away. If relief from the painful episode is obtained by nitroglycerin 1/100 grain under the tongue, one is even more convinced that the patient has angina. If the pain or distress in the chest continues for more than five to ten minutes, and if evidence of cardiac embarrassment develops, the chances are that the condition is not angina pectoris, but the more serious disorder, coronary thrombosis.

Treatment

The treatment of the acute attack consists of relieving the pain in the upper sternum by giving nitroglycerin 1/100 grain under the tongue and asking the patient to inhale the contents of an amyl nitrite ampule. The subsequent management, which does not require the absolute rest which some prescribe, includes regulation of the patient's life accomplished by limiting the quantity and quality of work, by refraining from exercise, and by avoiding the things that the patient knows will precipitate an attack. As hypertension often accompanies angina pectoris, the treatment of the hypertension by the usual methods is indicated. The xanthine drugs, sedatives, and regulation of the diet and work are as helpful for the one condition as they are for the other. Among the restrictions that should be rigidly enforced is the prohibition of tobacco.

Coronary Thrombosis

In sharp contrast to angina pectoris, coronary thrombosis always constitutes an immediate emergency. It may have some of the features of angina pectoris, such as pain in the upper part of the chest with radiation to the neck and down the arms. It too comes on in people over 40 years of age, but the attack usually occurs independently of exercise, emotional disturbances, and heavy meals. It may come on while the patient is asleep. The distress does not disappear in a few minutes, as in angina pectoris, but, as the minutes wear on, the pain takes on a tighter grip and is not relieved by the simple remedies used in angina pectoris. The main characteristics concern the heart muscle itself. The blood pressure falls, and the pulse becomes rapid and irregular, although it occasionally remains normal. Other evidences of cardiac collapse may develop. A slight pulmonary edema recognized by the presence of medium sized crepitant râles in the bases of both lungs, cyanosis of the lips, cold, clammy perspiration, and extreme exhaustion all point to cardiac collapse. Sometimes the pain does not begin in the chest but in the upper abdomen, and gallstones, colic, or upper abdominal catastrophes may have to be considered. This is especially true when nausea, vomiting and so-called acute indigestion predominate the clinical picture, particularly when the heart on first examination is slow, the pulse beat normal, and the blood pressure not greatly reduced. Several prominent ailments must always be considered when pain in the chest is present. They are spontaneous pneumothorax, pulmonary embolism, massive collapse of the lung, and pain in the upper abdominal viscera referred into the chest.

The Differential Diagnosis

In making the differential diagnosis, one must not rely upon ones instinct entirely but must consider the case in a methodical manner to avoid fallacious conclusions. If the history of the onset and preceding events can be obtained, it is very helpful. The age of the individual and the past history of a few attacks of acute indigestion are important differential considerations. While the patient with a gallstone may be of a corresponding age and have similar early manifestations of coronary thrombosis, yet the evidences of cardiac collapse typical of coronary thrombosis are not a part of the gallstone picture. Careful inspection of the patient is worthy of consideration. Very few diseases cause the extreme prostration and collapse of coronary thrombosis. When first seen, the patient is usually in agony, and, while the pain may be in the upper abdomen,

it has the distinguishing feature of being referred dominantly into the chest and frequently down the arm. The pain is unrelenting and does not respond to the usual measures used in other types of colic. A distinct ashen pallor and cyanosis are characteristic. Dyspnea and coughing associated occasionally with foamy expectoration indicative of pulmonary edema are present. Nausea and vomiting are common.

Palpation may reveal an irregular enlargement of the heart, but the heart may appear to be quite normal to superficial examination. Palpation of the abdomen does not reveal the tenderness found with acute abdominal diseases, nor is the rigidity of the abdominal wall such as is elicited by the perforation of an organ. Auscultation may bring out an irregular heart action, but auscultation of the abdomen in coronary disease does not reveal the absence of abdominal gurgles, such as is found in severe abdominal catastrophes. Further examination, especially of the bases of the lungs, shows râles in coronary thrombosis.

When there is doubt after the superficial examination is concluded, the rule is to treat the patient as a case of coronary thrombosis, because the law of averages will substantiate this impression. The diagnosis in most instances must be made without instrumental collaboration. Occasionally an electrocardiograph is available and is helpful, but the tracing is sometimes more confusing than illuminating and often shows nothing specific. In the end, one must rely on his clinical examination and judgment.

I must not pass over the diagnosis of coronary thrombosis without a word concerning the group of cases in which there is no pain. While estimates vary, probably about 15 to 25 per cent of these patients have a painless coronary thrombosis.

Treatment

The emergency treatment of coronary thrombosis is built around four chief procedures: 1. Rest must be obtained. This means that the physician must take complete charge, clear the room of all curious onlookers, and place the patient in a semireclining position or in the position most comfortable. Then ⅓ grain of pantopon should be given intramuscularly, or ¼ grain of morphine hypodermically, or, probably best of all, ½ grain of papaverine intravanously. Morphine is less well tolerated than the other two drugs, is less gentle to the patient, is more apt to cause nausea and vomiting, but probably is the master drug for the relief of pain. 2. As the patient may be in a state of collapse, 7½ to 15 grains of caffeine sodiumbenzoate given subcutaneously every few hours should be used to counteract the state of shock. Coramine, sometimes a lifesaver, should be given intravenously. 3. Oxygen is the sovereign remedy. If the patient cannot be moved to the oxygen, that is, into the hospital, then the oxygen must be moved to the patient. 4. An intravenous injection of 8 grains of aminophylline with 50 cc. of 50 per cent glucose solution has often been followed with relief from the pain of the shock syndrome and of pulmonary edema.

Digitalis is contraindicated, as is epinephrine. Five grains of quinidine sulphate every three or four hours may be employed to prevent ventricular fibrillation, but the good it does is problematical.

Cardiac Irregularities

Although the cardiac irregularities such as auricular fibrillation and flutter, paroxysmal tachycardia, extra systole, and heart block are not in the same category of emergencies as coronary thrombosis, one is often called to see a patient who has become anxious because of one of these arrhythmias. Simple tachycardia is caused by the chain of impulses that start in the auricle, ventricle, or auriculoventricular node. It is difficult to differentiate them at bedside examination.

Paroxysmal Tachycardia

In paroxysmal tachycardia, the paroxysm starts abruptly and ends the same way. The heart is usually very normal between the paroxysms. The fluttering of the heart causes great discomfort in the throat, the chest, and sometimes the abdomen. While this disease usually occurs in nervous individuals without genuine heart disease, it may appear

in association with heart disease. Therefore, the appraisal of the condition depends to a large degree upon the condition of the heart muscle itself.

The attack may be controlled in one of several ways. Pressure over the carotid sinus in the upper part of the neck may be effective. Pressure should be maintained for one to two minutes. Sometimes an ice pack on the precordial area will check it, but the most effective method is 10 to 15 grains of quinidine sulphate given at once, then 5 grains once or twice a day, and finally a few grains once a day to protect the patient from subsequent attacks. Occasionally, digitalis will regulate the paroxysmal tachycardia and prevent further attacks when other measures fail. Paroxysmal tachycardia is often generated by drinking coffee to excess, by excessive smoking, and sometimes by excessive drinking of liquor.

Paroxysmal Auricular Fibrillation and Flutter

The irregularities known as paroxysmal auricular fibrillation and flutter associated with a very rapid ventricular beat can usually be recognized without difficulty. They are often allied with genuine heart disease in contrast to paroxysmal tachycardia, in which genuine heart disease usually is absent. Fibrillation is found in connection with mitral stenosis in most instances, but it may occur independently.

Acute auricular fibrillation or flutter is controlled by giving digitalis in full therapeutic doses, such as 3 or 4 grains of the powdered leaf a day. In addition, such sedatives as phenobarbital or seconal are helpful. If digitalis does not alleviate the condition speedily, quinidine sulphate may be given in 5 grain doses three or four times a day. Quinidine must be used with great care in fibrillation that has been present for a number of weeks or months, but it is the drug of choice when fibrillation is acute, as in an emergency.

Extra Systole

Though of common occurrence, extra systole is probably the most innocent of heart disorders. Extra systoles are more of a nuisance than a disease and are not very important, but they may cause great discomfort at night when they interfere with the patient's sleep. Such factors as fatigue, liquor, tea, coffee, and tobacco are the main causes.

While many recommendations for treatment may be given, the restriction of the causative factors must also be effected. The actual treatment of extra systole may be outlined as follows: 1. The administration of 5 grains of quinidine sulphate three times a day for a week, then twice a day for a week, and then only occasionally abolishes the disturbance as a rule. 2. Occasionally the extra systoles are controlled by pressure on the carotid sinus. 3. The attacks are often abolished when the individual is convinced that they are of no consequence. This psychotherapeutic measure is more helpful than many would think.

Heart Failure

Usually when the heart fails, all chambers participate in the cardiac deficiency. However, this is not always true, especially not in the earlier stages of failure when the symptoms of heart exhaustion may be predominantly either of the right or left chamber. But if heart failure persists, and particularly failure of the left side of the heart, the right side will eventually fail too. Left ventricular failure is considered the most common cause of insufficiency of the right side of the heart, and incompetency of the left side occurs more frequently than that of the right.

The Treatment of Left Ventricular Failure

The treatment of left ventricular failure is, to a large extent, built upon fundamental changes in the pathologic physiology of the cardiovascular system. The chief principles may be epitomized as follows:

a. Absolute rest in bed for a number of weeks is imperative.

b. The patients obtain greater relief when allowed to sit up in bed than when lying flat.

c. Oxygen is given, especially if cyanosis or dyspnea persist. It is wise to give it in any case of heart failure.

d. One-quarter grain of morphine with 1/150 grain of atropine are sometimes necessary to quiet the patient and relieve dyspnea, but for a long time we have realized that

morphine is a double edged sword in the therapeutics of heart failure and that it must be used sparingly.

e. Fifty to 100 cc. of 50 per cent glucose solution with 7 grains of aminophylline may be given intravenously to augment the pulmonary circulation and relieve dyspnea.

f. One and one-half grains of digitalis purpurea or digitalis lanata is usually indicated. If one desires rapid digitalization, 1/100 grain of strophanthin may be given at once and repeated in six hours, providing no digitalis has been given previously. Five cat units of oubain may be given intravenously with 6 cat units of digitalis administered orally.

g. The fluid should be limited to 1,200 to 1,500 cc. a day and the salt in the diet kept at a low ebb.

h. Diuretics, such as diuretin, are often too irritating to the stomach; mercupurin in 1 cc. doses or a similar preparation may be given in the forenoon for a few days in succession. Peripheral edema need not be present before mercupurin is indicated, since the mercurial diuretics often relieve the dyspnea as well as the edema. Anedemin may be helpful.

i. The cough is usually relieved when the circulation of the lungs is improved. Occasionally ½ grain of codeine phosphate or codeine sulfate may be given with ammonium chloride in a proper vehicle three or four times a day.

j. When an acute attack of paroxysmal dyspnea sets in, aminophylline administered intravenously is generally sufficient to relieve the distress. If not, a narcotic such as ⅓ grain of pantopon may be resorted to.

k. Often the paroxysmal dyspnea that comes on at night may be prevented if the patient takes 3 grains of aminophylline by mouth before going to sleep.

l. The diet must be simple and non-gas producing, and the bowels must be controlled so that distention of the abdomen with gas is kept at a minimum, as this augments the dyspnea already present from heart failure.

The Treatment of Right Ventricular Failure

The fundamental principles emphasized in the treatment of left ventricular failure prevail also in right failure, but there are a few important differences which I shall emphasize. The rest, oxygen, aminophylline, digitalis, fluid limitation, diuretics, and diet may be patterned after the rules laid down above. However, in right failure, the venous congestion occasionally may be so great in the periphery and the venous pressure so high that nothing short of a venesection of one pint or more of blood will serve to relieve the patient. This should be done and repeated once or twice within a period of a week, if necessary, for the relief of symptoms. In right ventricular failure, an effusion of fluid often is present in the chest cavity and will compress a lung; this naturally is followed by an augmentation of the dyspnea. Thus, the heart failure, which results in accumulation of fluid in the chest, is in turn made worse by the ensuing reduction of lung volume, and the vicious circle must be broken by the removal of the fluid by thoracentesis. The same principal treatment applies to the accumulation of fluid in the abdominal sac. The employment of diuretics has a special place in right ventricular failure, because the symptoms are much more responsive to diuretics of the mercury group than those of left failure.

The Treatment of Congestive Heart Failure

The treatment of congestive failure may be divided into two classes: the immediate and the remote. The immediate treatment embraces the twelve items listed under the treatment of left failure. The treatment of the so-called remote factors is concerned with the precipitating cause of heart failure, such as infections, indiscriminations, and associated disorders. Frequently in congestive failure, as in right ventricular failure, the cardiac insufficiency causes pleural effusion, and the fluid must be removed to break the vicious circle caused by the effusion.

In conclusion, rest is one of the most important principles in the treatment of heart failure. Safeguarding the patient with a damaged heart against influences which precipitate failure is of primary consideration. A proper way of living may be more important than a prescription for medicine. And,

finally, it has always been known by astute physicians that disease of the heart is as much a psychic disorder as a somatic one. Fear of death, and especially of sudden death, is a feature of heart disease. In addition to the treatment given in this paper, one of the best therapeutic aids is to add a word of encouragement to the patient. When visiting a patient with cardiac disease, always remember to speak and act in such a manner that his outlook will be improved.

Embolism

In heart failure, auricular fibrillation, or coronary obstruction, embolic phenomena are likely to occur. Mural thrombi develop because of the dilatation of the chambers and the slowing down of the blood flow. These thrombotic masses may form on the walls of either auricle or ventricle. In coronary disease the infarct may involve the endocardium and lead to a thrombus over the softened area. At times a piece of the thrombotic mass breaks off and lodges in the extremities or in some essential organ in the body. If the embolism lodges in the brain, paralysis results and the prognosis is poor. An embolism of the spleen or kidney may be better borne. Pulmonary embolism with dyspnea, hemoptysis, cyanosis, and cough may also occur. The outlook for the patient in these embolic accidents is dependent upon the size of the embolus and the organ in which it lodges. Specific treatment consists of the injection of 1 grain of papaverine hydrochloride intravenously and 1 ampule of metrazol subcutaneously. Other measures are purely symptomatic.

Summary

1. The importance of the initial treatment in cardiac emergencies, which usually occur in the home, is emphasized.

2. The chief role of the physician who is first called is to determine whether an actual heart attack has occurred or if there is a condition simulating it.

3. The following diseases are considered to be the outstanding emergencies encountered in the home.

a. Coronary disease, including angina pectoris and coronary thrombosis.
b. The cardiac irregularities, such as paroxysmal tachycardia, auricular fibrillation, and extra systole.
c. Heart failure.

4. The differential diagnosis of these conditions is briefly outlined, and the treatment of some of them is given in more detail.

5. Special attention is given to the simple measures that may be employed effectively in any case when the threatening disaster develops at home.

6. Although the special facilities such as electrocardiographs and roentgenograms are necessary for precision in diagnosis and treatment, it is pointed out here that in most instances they can be easily dispensed with and that clinical experience, skill, and judgment constitute the requirements for treatment of these cases.

TWENTY DAYS ADVANCE NOTICE REQUIRED TO FILE NEW RESOLUTIONS ON BUSINESS

Chapter III, Section 9, of the By-laws of the State Medical Society of Wisconsin:

"Unanimous consent of the House of Delegates shall be required for the introduction of any new resolution or business not filed in proper form with the secretary's office of the Society twenty days before the first session of the House of Delegates. This section shall not apply to new business or resolutions presented by the Council, the constitutional officers, committees of the Society or of the House of Delegates, or officers of the House of Delegates."

The Hospital Treatment of Cardiac Cases*

By ALVIN G. KOEHLER, M. D.
Oshkosh

A. G. KOEHLER

Dr. Koehler received his M. D. degree at the Hahnemann Medical College and Hospital of Philadelphia, Pennsylvania, in 1912.

IN MY discussion of the hospital treatment of cardiac cases, I shall consider only such cases as we treat most frequently in the hospital. In regard to each type of cardiac disease discussed, I am taking it for granted that the proper diagnosis has been made by the various procedures which Dr. Paul White evaluates as follows: history of case, 45 per cent; physical examination, 35 per cent; electrocardiogram, 10 per cent; roentgenogram, 5 per cent; and other laboratory tests, such as urinalysis, blood count, and Wasserman, 5 per cent.

Acute Coronary Thrombosis

The first consideration in the treatment of a case of acute coronary thrombosis of such severity as to require hospitalization is complete bed rest. This means that the patient should not be permitted to move about in bed and that the nursing care and medical examinations should be given in such a way as to disturb the patient as little as possible. As it takes the infarct about four weeks or more to be filled in with connective tissue, and complete healing does not take place for from four to six months, the patient should be kept in bed at least five or six weeks or longer. Then he can gradually be allowed to get about; however, each patient must be studied individually. At least six months or a year should elapse before he returns to his work, which should then be carefully regulated and limited in accordance with his capacity.

The Administration of Sedatives

Morphine sufficient to relieve the pain, usually ¼ grain, should be given; ½ grain may be necessary. After a day or two, 10 minims of tincture of deodorized opium should be administered every two hours for 10 doses. This should be reduced to 80 minims every twenty-four hours, then 60 minims, then 40 minims. The dose of 40 minims in twenty-four hours can be given for six weeks as a general sedative. I am a firm believer in the use of oxygen, either by nasal catheter, mask, or tent. This aids in the relief of pain, dyspnea, cyanosis, and restlessness. For sleep, one of the phenobarbital group can be given.

At the Mayo Clinic, a 200 to 300 cc. 20 per cent hypertonic glucose solution with the addition of 3¾ grains aminophylline is given intravenously. This should be given very slowly so that its administration takes from one to one and one-half hours. It is especially effective in controlling nocturnal dyspnea and Cheyne–Stokes breathing, and it aids in relief of pain. This solution is used also in congestive failure. However, Murphy adds a word of warning: In volumes of 100 to 200 cc. of strongly hypertonic solutions, about 20 per cent of grade III and half of grade IV cases of cardiac disease will be made worse. In volumes of 50 cc. with or without aminophylline, the dyspnea and pulmonary edema will be improved in all grade IV cases of cardiac disease.

Digitalis is absolutely contraindicated unless there are symptoms of congestive failure. These rarely occur during the first two weeks of the attack. Epinephrine is also contraindicated.

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In cases of diabetes, insulin should not be given, and in persons with syphilis, intravenous antisyphilitic treatment is contraindicated, nor should intravenous gall bladder dye be given.

Levine gives 3 grains of quinidine three times daily for two weeks after an acute attack to prevent ventricular tachycardia and fibrillation. I have not done so unless it was especially indicated.

Theobromine, theophylline, or aminophyline are given by some physicians as routine treatment.

As for diet, a patient with acute coronary thrombosis should receive very little food the first three or four days, and that should be liquid or semiliquid and fed to him by the nurse. It is best also not to give cathartics or enemas for two or three days. Later, an easily digested diet, omitting the foods which produce distention, should be given.

Coronary Sclerosis

Coronary sclerosis is almost exclusively atherosclerosis which is distinguished from other forms by the presence of cholesterol in the lesions. These cases should therefore be placed on a low cholesterol diet. Dr. Timothy Leary brought this out in his lecture at the Academy of Medicine Fortnight at New York during the fall of 1941. He proved by experiments on rabbits that the excess cholesterol is stored in the liver and adrenals and finally escapes into the blood stream in the form of foam cells which finally invade the arterial intima and produce the characteristic lesions. A low cholesterol diet is therefore indicated. This consists of the elimination of all animal fats from the diet, such as cream, cream cheese, fats, lard, pork, and eggs, and also some vegetables, such as onions, cabbage, turnips, radishes, and cucumbers.

Congestive Heart Failure

Another type of cardiac disease frequently seen in hospital practice is that of congestive heart failure. Here we cannot expect to bring about a cure but only to diminish suffering and to prolong life. The patient is an individual perhaps between 40 and 50 years of age who has had a mitral stenosis for years. He has lived an ordinary life without much special care of his cardiovascular system.

He is now admitted to the hospital with edema of the ankles, an enlarged and tender liver, râles at the base of the lungs, and perhaps a slight amount of fluid in the right side of the chest. The heart is enlarged, and the pulse is irregular, with a rate of 120. The blood pressure is slightly elevated. A diagnosis of mitral stenosis with auricular fibrillation is made.

The first thing to do is to place the patient at absolute rest in bed in the position in which he can breathe best. If he is able to read, listen to the radio, or enjoy another similar, restful pastime, he may do so, but he should have very few visitors. His mind should be at ease. For the first few nights, it may be necessary to give him 1/6 to 1/4 grain of morphine, especially if he has much dyspnea. Later on, as he improves, one of the other sedatives such as phenobarbital or a bromide may be used.

As for diet, it should be one which contains the proper mineral and vitamin content and also the sodium salts, but the physician should limit fluids to 1,000 cc. in twenty-four hours.

The bowels should be kept open, but drastic purges should not be given.

Chronic cardiac decompensation affects the functions of practically every organ in the body. These changes are due to lowered cardiac output. Digitalis increases this cardiac output.

As for drugs, digitalis is the drug par excellence in congestive heart failure. However, this drug is very much abused by its use by the medical profession. In the cardiac clinics at the Cornell Medical Center, only about 1 case out of 7 gets the drug or needs it. Only about 15 per cent of all patients with cardiac disease require digitalis, while the other 85 per cent should not have it. It is ineffectual and should not be used in the rapid pulse of fever or toxic goitre without fibrillation, acute infections, pneumonia, preoperative or postoperative care, or peripheral failure as exhibited in shock.

Use of Digitalis

Digitalis should be used only in myocardial failure and in certain disorders of rhythm, such as auricular fibrillation, flutter, and paroxysmal tachycardia. It is, however, very useful in myocardial failure with congestion of either the pulmonary or systemic systems, or combinations of both. If congestive failure is present, there are no contraindications to its use, even in coronary disease, hypertension, and rheumatic endocarditis. In other words, if coronary thrombosis is accompanied by no signs of congestive failure, the use of the drug is contraindicated; however, just as soon as symptoms of failure appear, digitalis may be given to combat the failure.

Dr. Gold of Cornell University has brought out the fact that digitalis slows the heart first by its action on the vagus nerve, which action can be abolished by atropine, and extra vagal action, which cannot be abolished by atropine. Thus, in auricular fibrillation, the pulse can be slowed while the patient is at rest but becomes much more rapid when the patient exercises. At this point, only the vagal action of digitalis is in effect; however, by using the drug, the extra vagal action also is obtained, and the pulse will now remain slow after exercise.

As for dosage, one must get the patient digitalized and then keep him on a maintenance dose. In takes about 25 to 30 grains of the leaf to digitalize the patient in twenty-four to forty-eight hours, depending upon the size of the patient. It is not wise to give the entire dose at one time, as very large doses produce a strong emetic action, but 5 grains every six to eight hours until the 25 to 30 grains are given and then 1½ to 3 grains daily to maintain digitalization is the proper dosage. The average patient eliminates about 3 grains daily if he has 30 grains in his system, and he therefore requires about 3 grains daily as a maintenance dose. However, if you start him on only 3 grains daily, he does not eliminate 3 grains daily but only a fraction thereof until he has accumulated the 30 grains in his body. This takes about a week. For this reason, this so-called tonic dose affects the patient, has the same result as the first method, and is really the same only slower; consequently, it is effective.

I call your attention also to the fact that a dose of digitalis by mouth and an equal dose by vein and hypoderm are not the same. About five times as much digitalis by mouth is required because of the inert material in the drug which is not absorbed as it is by vein.

Of late years, the purified glucosides of digitalis have been studied. Gold has found that with digitalin nativelle or digitoxin the same dose, namely, 3 cat units, either by mouth or intravenously in a single dose, will produce digitalization in six to ten hours, which shows that all of the glucoside is absorbed in the intestinal tract.

Gold also found that the assays made by the frog method varied from that made by the cat method. In fact, one drug supply house now has digitalis on the market which is assayed on human beings, and I feel that this is the best method.

Effect of Diuretics

Diuretics produce no change in the cardiac output such as digitalis does. However, they cause marked improvement in edema, cyanosis, and dyspnea. The xanthines, such as theophylline, theobromine, theocalcin, and aminophylline, are mild diuretics.

The organic mercurials are far more potent. These work best if 7½ grains of ammonium chloride or nitrate in the form of enterin coated tablets are given three or four times daily for a few days in advance.

Salyrgan with theophylline given intravenously every third to seventh day usually is very satisfactory. Contraindications are acute nephritis or ulcerative colitis. A delayed action from salyrgan may occur. The Mayo Clinic reports a case which showed no results for the first month of treatment.

Five grams of potassium salts—chloride or nitrate—should be administered daily, and the sodium salts should be eliminated from the medicine and diet. Thirty to 60 grams of urea daily acts as a diuretic, as does bismuth sodium tartrate.

Thoracentesis, abdominal paracentesis, and the insertion of Southey's tubes into the legs

may, in persons with intestinal disorders, remove enough fluid so that the drugs can work more effectively.

Subacute Bacterial Endocarditis

Were I called upon to treat a case of subacute bacterial endocarditis at the present time, I would, after making the proper diagnosis, follow the treatment first used by White and Kelsin at the Massachusetts General Hospital. This consists of giving sulfapyridine or one of the other sulfonamides in doses of 4 to 6 Gm. daily so as to get the blood level to 10 mg. per cent. The temperature usually drops to normal in a few days, and after a week the heparin treatment is begun intravenously and continuously day and night for fourteen to twenty-one days. Twenty cc. of heparin to 1,000 cc. of normal saline are administered, 15 to 20 drops a minute so as to keep the clotting time at one hour. The "sulfa" drug is continued during this time and for at least two months longer.

The tendency now is to give the "sulfa" drugs alone. However, I would try sulfapyridine and use coumarin, the spoiled sweet clover extract, as an anticoagulant. The fever treatment with typhoid serum and heat cabinets has also failed.

High caloric and high vitamin diets, vitamin C, and iron are given. Transfusions and other aids are given if necessary.

The use of sulfapyridine for a few days before and after operations in order to prevent the onset of subacute bacterial endocarditis in patients with rheumatic endocarditis is of value.

The Kenny Concept of Infantile Paralysis*

By WALLACE H. COLE, M. D.**
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THE medical profession must, of necessity, always examine closely all new developments and ideas before accepting them as part of the science of medicine, and a certain healthy skepticism is needed if the standards which we set up for ourselves are not to be lowered by unfounded enthusiasms and fads. This skepticism, however, must not consist of a complete shutting off of new ideas from the mind or a refusal to discuss changes of thought, and, certainly, none of us should rush into print to defend the old without having at least some conception of the new. Anyone with a background of medical history will reserve judgment even on seemingly fantastic ideas until the time when competent observers have studied and passed upon them or clinical trial has proven things one way or another. Unfortunately, there are members of our profession who do not remember how some of the great advances in medical science came about and who scoff with closed minds at ideas which are a reversal of their own acccepted medical thought, especially if these ideas are originated by one who is not a physician. This has been demonstrated many times during the last two years to those of us at the University of Minnesota who have been working on the Kenny method in infantile paralysis and who have become advocates and followers of the teachings of Miss Kenny. To these scoffers and also as a reminder to the rest of us, it is pertinent to quote from Oliver Wendell Holmes, who stated that medicine learned "from a Jesuit how to cure agues, from a friar how to cut for stone, from a soldier how to treat gout, from a sailor how to keep off scurvy, from a postmaster how to sound the Eustachian tube, from a dairy-maid how to prevent small-pox and from an old market-woman how to catch the itch-insect." In all humility, I suggest that the following be added: "and from an Australian nurse how to treat acute infantile paralysis."

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** From the University of Minnesota Medical School, Minneapolis.

Elizabeth Kenny Seeks Recognition in the United States

This nurse, Elizabeth Kenny, when left to rely upon her own initiative with no medical supervision, developed a conception of infantile paralysis which was based on keen observation of the cases coming under her care. This concept had no relationship to the usual textbook teachings nor to the accepted pathology, of which she was ignorant, and described a condition, the picture of which was the exact opposite of that universally taught. Her observations were original with her, and the results obtained by her treatment were apparently so much better than in the cases treated by the standardized methods that eventually she obtained full recognition by her government, and clinics were set up to make the method more available to those suffering from this much dreaded disease. There was active opposition on the part of the members of the medical profession, which was probably to be expected, and only relatively few of them came to accept her theories and ideas. Even after many years of proven results, the method was usually mentioned only to be laughed at, and few, if any, unbiased studies were ever made.

Knowing that a scientific background and explanation were necessary if full recognition of her work was ever to be received, Miss Kenny came to this country in 1940, hoping to arouse an interest in research on her specific problems. She was none too cordially received in the various cities she visited and was returning to her home and clinics in Australia when we at the University of Minnesota had a chance to talk with her and have her demonstrate her ideas on some of the patients being treated by us along conventional lines. Previous reading of the few articles in the medical literature had interested me in the ideas brought forward by Miss Kenny, and her name was not unknown to me, but I found out within a few minutes of my first contact with her that I had had absolutely no conception of what she was trying to get the medical profession to accept. Gradually, as one case after another was examined, a realization of her aims and the reasons back of the method with which she had worked for over twenty-five years began to be apparent, and it was felt then and there that, if possible, a study should be made under proper supervision to determine whether or not this conception, new to us at least, was better than that commonly taught and to reject or accept it after definite clinical observation. With this in mind, the National Foundation for Infantile Paralysis was asked through its president, Mr. Basil O'Connor, to finance the living expenses of Miss Kenny for six months, and a grant to the University of Minnesota large enough to keep her with us for that period of time was obtained. The Foundation realized that it was well worth while to make such a study, as it certainly is almost as valuable in any research to prove something wrong as to prove it right, and, if Miss Kenny's work turned out to be as absurd as some people seemed to think, it could be eliminated from future thought.

Research Begun at University of Minnesota

The National Foundation for Infantile Paralysis has, therefore, financed a study of the Kenny treatment of infantile paralysis at the University of Minnesota since June, 1940. This study has been directed by the Departments of Orthopedic Surgery and Physical Therapy and has been carried on at the University Hospital and the Minneapolis General Hospital. Miss Kenny herself has been in personal charge of the work except for an interval in the late winter and spring of 1941, and she is still working actively at the University. In January, 1941, after the first period of observation, a preliminary report was submitted to the Foundation which was later published with some deletions in the *Journal of the American Medical Association* for June 7, 1941. In that report we committed ourselves to the Kenny concept and method and concluded that it would be the basis for the future treatment of infantile paralysis.

Further study and observation have shown us that these conclusions were not wrong, and those of us who have been associated with Sister Kenny feel strongly that the work must be continued and the method taught and used as widely as possible, for

we know that far better results than ever before are being obtained in the treatment of acute infantile paralysis.

It must be understood from the beginning that the Kenny ideas are not mere additions to the older concepts of infantile paralysis but that they are revolutionary and have little in common with these older concepts. We are dealing actually with a different disease than the one commonly described and are dealing with it therapeutically in the acute stage. As pediatricians and practitioners, we have treated these patients in the past for fever, headache, and gastrointestinal disturbances, we have removed mucus and secretions from the air passages, and we have put patients with respiratory distress into respirators. As orthopedists, not recognizing the actual symptomatology of the disease, we have treated what we considered a flaccid paralysis by splinting to hold the parts at rest and in good position and to keep the apparently paralyzed muscles relaxed. It was realized that all our treatment left something to be desired, that contractures and deformities not infrequently occurred in even the best handled cases, and that a certain amount of joint stiffness was not uncommon; but the apparent good results from rest and fixation seemed for many years to outweigh greatly these complications. Then reports began to appear showing that untreated cases were frequently better off than those which had been under treatment, and Miss Kenny arrived in this country to show us, at least to a certain extent, why. Whether or not one accepts her teachings, and the skeptics are getting fewer and fewer, it must be admitted at least that, as a result of her presence, research in infantile paralysis has been so stimulated that much more will come out of her visit than was expected in the beginning or was ever dreamed of even by herself.

The Main Object of the Kenny Concept

To understand this new concept, it is necessary first to make a difficult mental adjustment and accept the teaching that the opposite of the traditional symptomatology is present. Let me emphasize here that the Kenny treatment is primarily for the acute stage of a new disease which is different from our earlier concepts of infantile paralysis and that the whole future of a case depends upon getting this treatment started early. Every day is of importance, and a delay of ten days or more can sometimes do irreparable harm. This does not mean that the treatment cannot be tried in cases of longer duration, but it does mean that the Kenny treatment should not be judged according to the results or lack of results obtained in such cases. An attempt is being made to find out just how much improvement can be obtained in cases of several months' or years' duration in which contractures, deformities, and stiffness are shown, but this study is secondary to the main object, *the treatment of acute infantile paralysis.* We know that in some of these older cases a definite and sometimes remarkable improvement has been obtained but that in others, even after prolonged trial, little has been accomplished. In those older cases which show complete paralysis of an extremity, there is probably no reason for even giving the method a trial. We who are so interested in placing the proper concept of Miss Kenny's work before the medical profession realize that misdirected and untrained efforts not only in the choice of cases but in the application of the treatment (and we have been guilty of this ourselves) do much to discredit the work, and it is hoped that all judgments will be based only on the results obtained by properly trained Kenny technicians in acute cases, for which the system primarily is indicated. The other work must be only a corollary to this and must not be used as an argument for or against the method.

The conception of infantile paralysis and its treatment as evolved by Miss Kenny cannot be mastered or even understood in a short time, and personal instruction by Miss Kenny or one of her trained technicians is certainly the best way of acquiring a knowledge of the method. Realizing that everyone cannot get this instruction and that the method would be tried in spite of ignorance of its fundamental principles, some of us have published through the National Foundation for Infantile Paralysis a pamphlet

which tries to outline the whole idea and is largely an epitome of what appears in the larger book written by Miss Kenny herself. The pamphlet does not replace the book in any way but is merely an attempt to get better treatment started over a larger area on cases of infantile paralysis than would be possible otherwise. Eventually it is hoped that personal training by competent Kenny technicians in many centers will be available to all who desire it, and our classes at the University of Minnesota will continue as long as there is a demand for them.

To describe the Kenny method further means quoting freely from the various articles which have appeared, from Miss Kenny's book, and from our own pamphlet, and the description can be only a brief outline of what has been written. I apologize for the plagiarism and refer you to the originals for more detailed descriptions.

The Cardinal Symptoms of Infantile Paralysis

The cardinal symptoms of infantile paralysis are (1) muscle spasm, (2) incoordination, and (3) mental alienation. This means that it is recognized that other portions of the central nervous system beside the anterior horn cells are involved in the acute disease and consequently, that simple flaccid paralysis, which has been the major accepted symptom in the past, must be considered in a different light. Of course, there are cases in which a very severe infection causes immediate destruction of large portions of the anterior horn greymatter, and a complete flaccid paralysis of certain muscles or parts supplied by these areas necessarily results.

Muscle Spasm

Muscle spasm, with which we must include pain, for the two apparently go together, has been recognized for years as being present in acute infantile paralysis, but never before has it been considered the major symptom of the disease and the cause of many of the after effects. It consists of a more or less tonic state of contraction of the muscle fibers, a hyperirritability of the muscle to stretching, sometimes fibrillary twitchings, and, in general, a condition in which the involved muscle is tending to shorten itself. This is accompanied by the inability to relax or lengthen. The condition is widespread throughout the body and can be found when looked for in parts not considered involved under the standard conception. There are few cases which do not have involvement of the back and neck muscles, formerly ascribed to meningeal irritation, the hamstrings, and the calf muscles. Examination of a patient acutely ill with infantile paralysis shows an individual whose muscles are tender, painful, and in spasm; these symptoms are markedly increased if an attempt is made passively to stretch the muscles. Weakness and apparent paralysis usually are due to these symptoms and not to a flaccid paralysis.

The end results of untreated spasm are shortening and fibrosis in the muscles involved, contractures and deformities, and limitation of joint motion secondary to these. The cause of the spasm in infantile paralysis is still a debatable point, but the very recent work of Schwartz seems to show that it might be entirely reflex in character and not due in any way to local action of the disease on the muscles themselves. A great deal of other interesting work is being carried on in various parts of the country in an endeavor to discover the mechanism of spasm. It is to be hoped that our knowledge of this symptom and its treatment will be more definite soon.

Mental Alienation

Spasm is directly responsible for what is called "mental alienation" and probably acts in several ways to produce this symptom. Mental alienation merely means the inability on the part of the patient to move a muscle actively and purposefully although there is no anatomic break in the regular nerve supply to that muscle. It is analogous to the condition not infrequently seen in painful or postoperative knee joint lesions in which the quadriceps fails to function and refuses to contract. As has been stated, any attempt to stretch an involved muscle in spasm increases that spasm and causes pain, and, consequently, the opposing muscle may be subconsciously divorced from control. In

addition to this, there is a stretching of the opposing muscle and a limitation of its power of action by the breaking effect of the muscle in spasm. These conditions tend to produce apparent, flaccid paralysis in the opposing or weaker muscles, and if this occurs, a true alienation is present.

Incoordination

Incoordination is that condition in which there is an attempt on the part of the patient to substitute the muscle action of surrounding muscles for that of the involved muscles by a change in the normal neuromuscular mechanism. If allowed to continue unchecked, the involved muscle or muscles may become permanently nonreceptive to motor impulses and then will remain paralyzed.

The Kenny treatment aims at combating these factors of spasm, alienation, and incoordination at the earliest possible moment. The two latter factors frequently can be entirely prevented from coming into the picture if the spasm is adequately handled and if proper muscle re-education is carried out. Since the major symptom of acute infantile paralysis is spasm, the most important and urgent therapeutic measures must be directed at this symptom. In brief, they consist of the use of special hot packs on the affected muscles, rest in the physiologic position in bed, and avoidance of all irritation which might aggravate the spasticity. The time for starting this treatmenn is the moment the diagnosis is made, and the contagious wards of our hospitals must therefore be the place where this is undertaken. Only in this way can the evils of spasm be controlled. Later, when the spasm has been released, meticulous muscle training can be started, "muscle awareness" developed, coordination in the use of muscles taught, and alienation further prevented. No splinting of any kind is ever used, and deformity is prevented by overcoming the deforming force of spasm. In this concept of infantile paralysis, deformities do not occur as a result of the unopposed pull of normal muscles but follow the contractions and contractures in the involved spastic muscles.

Respirators Not Used

Respirators are not used, and experience seems to show that if the spasm in the intercostal and other muscles of respiration can be treated properly, recovery is much faster and the end results necessarily better. It is believed that any case that can be saved in a respirator can be saved without the machine by the Kenny technic and that probably the percentage of recoveries in this serious group even can be bettered.

The Kenny idea, then, is that infantile paralysis is a much more generalized disease than it has been considered ordinarily, that the muscles become spastic, and that mental alienation and incoordination, secondary to the spasticity, account for a large number of the seemingly paralyzed muscles in residual cases. Proper treatment of the spastic condition will eliminate these after effects if the case is seen in the acute stage, and residual paralysis will be present only when the controlling nerve cells have been completely wiped out in a given area by the disease.

Conclusions

Experience with this method for two years has led to certain definite conclusions. It has not been tried by enough men as yet to prove the results in large groups of cases, and, of course, one can expect further developments and elaborations of the method based on the underlying empiric observations, but it is believed that the conceptions are fundamentally correct and that scientific laboratory work will bear them out. We have seen all of the symptoms Miss Kenny has described, and studies are being carried out in an endeavor to explain these scientifically. Among other things, we can make the following statements:

1. Muscle spasm is undoubtedly a prominent symptom of infantile paralysis in the acute stage.
2. Incoordination and mental alienation are the causes of certain apparent paalyses which can be cured by correction of these underlying causes.
3. Deformities, contractures, and resultant stiffening of joints can be absolutely prevented if spasm is overcome.

4. Splinting is not indicated in acute cases and may do great harm by increasing spasm.
5. Patients certainly are more comfortable and alert under the Kenny treatment than previously.
6. The cases treated by this method which have residual paralysis are in better shape for orthopedic operation later when indicated.
7. The percentage of recoveries is much higher than in earlier series.

The method is being tried out in subacute and chronic cases. However, it is not on these that it must be judged, as it is primarily aimed at the acute spasm present at the onset of the disease and followed, of course, by very careful training. The method cannot be expected to release well formed contractures or deformities. As some of the residual paralyses seen are directly or indirectly due to the spasm, it is logical to assume that with cases started on the Kenny treatment in the acute stage, there will be less residual paralysis present and that the percentage of cures will be higher. Our statistics definitely prove this.

It has been with the hope that better results will be obtained and less crippling seen following infantile paralysis that we have continued working with and teaching this method at the University of Minnesota. We are not advocating the Kenny method as a cure-all, for we know that some cases stricken with infantile paralysis will die or have residual paralysis, but we do know that in spite of this, the end results we are obtaining in acute cases are markedly better than ever before.

The Wisconsin Experience With the Kenny Treatment Methods

By HAROLD M. COON, M. D.
Madison

IN CONNECTION with Dr. Cole's paper on "The Kenny Concept of Infantile Paralysis," the experience of the two Wisconsin hospitals in which Kenny methods have been used during the past year, might be of interest.

According to the State Board of Health records for 1942, there were 43 cases of anterior poliomyelitis reported. Of these, 29 received the treatment as outlined by Sister Kenny and administered under the direction of technicians who had trained under her supervision. Eight were treated at South View Hospital, isolation hospital of the city of Milwaukee, and 21 at the Wisconsin Orthopedic Hospital for Children, a unit of the State of Wisconsin General Hospital, Madison.

The comment of Dr. Max J. Fox, medical director of the South View Hospital, follows:

"In the past year, 8 patients from 2 months to 17 years of age were confined to the South View Hospital with infantile paralysis. The Kenny method of treatment was used by a trained personnel. Three of the 8 patients left the hospital with complete recovery. The others left without deformity but had slight muscle weakness and some residual paralysis. A muscle re-education program was recommended to the attending physicians, or the case remained with the Outpatient Social Service Program. The results were most encouraging and verified the impression gained by other observers in adopting the Kenny method of treatment."

At the Wisconsin General Hospital, 21 cases were admitted to the hospital and given the Kenny treatment, 14 during their period of isolation and 7 varying from one week to two months after the isolation period. There were three deaths, all in cases with bulbar involvement. Fourteen were discharged showing definite improvement.

* Superintendent, State of Wisconsin General Hospital, Madison, and professor of hospital administration, the University of Wisconsin Medical School, Madison.

Sister Kenny and one of her patients.

Value of Treatment

As to the value of this type of treatment, first comes the comment that treatment is instituted early and that the use of the hot packs readily decreases the pain, irritability, and restlessness, so that only mild sedative drugs are required.

As to paralysis, there is no question that residual paralysis will occur, but partial paralysis is more readily corrected with this method of treatment.

When the older method of treatment is being used, contractures are noted and cause difficulty when the plaster casts are removed. When the Kenny method is used, contractures do occur in paralytic cases but are not due to the use of casts.

There has not been sufficient time to make any estimate of the decrease in the matter of residual deformities.

It would appear that there will not be the need for braces in as many cases as previously, but there is no question but that some of the cases will need stabilization.

Surgical reconstructive work can be started earlier after the use of the Kenny method; moreover, it appears that this will shorten the over-all period of treatment heretofore necessary for poliomyelitis cases. Also, the length of stay in the hospital is definitely shortened for the case in which there is only temporary paralysis, but it is not shortened for the case which shows residual paralysis at the end of a month of treatment. Furthermore, in regard to the length of hospitalization in the use of the orthodox treatment, considerable time is used to overcome the atrophies and contractures resulting from the use of plaster of paris casts. In the Kenny method, this costly period is obviated.

The use of the Kenny treatment in the chronic case has no apparent value, nor should its use be prolonged in the acute cases.

Summary

In summary, 29 of the 43 cases of anterior poliomyelitis reported during 1942 were treated with the Sister Kenny method of treatment in two hospitals under properly trained personnel. Of these cases, 22 are reported as being benefited by the treatment.

EYE HEALTH AND SAFETY NEWS

The National Society for the Prevention of Blindness is now publishing a bi-monthly newsletter, entitled *Eye Health and Safety News*, for free distribution among physicians, nurses, public health officials, social workers, educators, safety engineers, and others who are professionally interested in some aspect of sight conservation.

Each issue of *Eye Health and Safety News* contains a variety of brief items on developments and new projects in the campaign for prevention of blindness. A regular feature is the reporting of activities in this field carried on by official and voluntary state agencies.

Those who are interested in receiving this new publication regularly are invited to write to the Society, 1790 Broadway, New York (19), N. Y.

The Modern Treatment of Acute Osteomyelitis*

By ALBERT C. SCHMIDT, M. D.
Milwaukee

AT THE present time many of us are attempting to evaluate the sulfonamide therapy for acute hematogenous osteomyelitis. We know that it is of value, but just how much a patient is benefited will be determined only by further study. High doses of sulfonamides which are required to combat the disease may in themselves cause some untoward effects.

Data from the Mayo Clinic

Before the advent of sulfonamide therapy, a report by the Mayo Clinic in 1937 stated that the mortality rate for two cases of hemolytic Streptococcus osteomyelitis was 50 percent and that in eight cases of Staphylococcus aureus osteomyelitis the mortality rate was 75 percent. They also reported that in 61 cases of septicemia due to hemolytic Streptococcus there was a mortality rate of 71 percent. In 29 cases of Staphylococcus septicemia there was a mortality rate of 66 percent.

About a year ago I had the pleasure of observing 9 consecutive cases presented by Doctor Hoyt of Akron, Ohio. These patients were treated with large doses of sulfathiazole. There were no deaths. Surgery was not resorted to in a single case.

Today I am presenting 4 additional cases which were treated in the acute stage by sulfadiazine. In 2 cases an abscess had to be incised, but this was sometime after the acute stage.

Case Reports

Case 1. R. Z., an 11 year old boy, was admitted to the Milwaukee Children's Hospital on December 4, 1941. The mother stated that the child had struck his left leg against a cement block five days before. The pain increased daily. On admission he was complaining bitterly of pain in the left knee. Past history is of no significance.

Examination: On admission, the patient appeared acutely ill and presented a typical picture of an acute pyogenic infection. His lips were parched, and the skin was dry. He was rational. He cried continuously fearing that someone would touch his leg. The lower one-half of the femur, including the knee, was swollen. There was no fluctuation. Tenderness was exquisite on both the medial and lateral aspect of the lower end of the femur. The knee could be moved through an arc of 30 degrees with but slight discomfort. The rectal temperature was 103.8 F., pulse rate 112, and respiratory rate 28. The leukocyte count was 20,800, the erythrocyte count 5,200,000, and the hemoglobin 11.5 mg. The urine was negative.

A roentgenogram of the femur was essentially negative. Blood culture taken on December 5 revealed a hemolytic Staphylococcus aureus.

Diagnosis: Acute osteomyelitis of the left femur.

Treatment: Sulfadiazine was started immediately on the basis of 1 grain per pound of body weight per day. This was increased to 1¼ grains on the third day and was decreased to ½ grain on the ninth day. After the patient's temperature had been normal for twelve days and the sulfadiazine discontinued, it was interesting to note that the following day the temperature started rising, and the third day it was 101.5 F. He was again given sulfadiazine at the rate of 1 grain per pound of body weight per day for one week, after which the amount was reduced to ½ grain. On January 16, which was one month after the fever originally subsided, the sulfadiazine was again discontinued only to be followed with a rising temperature and pain in the affected thigh. It was then decided that we would continue with the sulfadiazine and maintain a blood level from 3 to 7 mg. per 100 cc. for a period of at least two months. The sulfadiazine was finally discontinued four months after admission to the hospital.

Two hundred fifty cc. of citrated blood was given daily the first four days in the hospital, and in addition the patient received 250 cc. of 5 percent dextrose intravenously on the second and third day. He probably had a reaction to the transfusion on the third day. His temperature rose to 106 F. Hot fomentations were applied to the leg during the acute stage. On admission, Russell's traction was applied to the leg.

A roentgenogram on December 13, 1941, showed an osteomyelitis of the left femur. He was discharged from the hospital on April 20, 1942.

Summary of Case: This is a typical case of an acute hematogenous osteomyelitis that was treated with sulfadiazine plus other supportive measures. There were two flare-ups following the discontinua-

* Presented before the One Hundred First Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1942.

tion of sulfadiazine at too early a date. Clinically he has completely recovered.

Case 2. D. P., a 10 year old girl, was admitted to Milwaukee Children's Hospital on January 7, 1942. This patient had had an earache about two weeks prior to admission. On January 5, she developed a backache, which was followed with a chill. Past history is of no significance.

Examination: Examination revealed a well developed girl complaining bitterly of pain in the back. Examination was most difficult because of the marked muscle spasm of the extensor muscles of the hip and the posterior muscles of the back and neck. The picture was that of an acute meningeal irritation. There was no swelling over the spine, but tenderness was rather generalized over the lumbar region. The abdominal reflexes were present. The reflexes in the upper extremities were somewhat hyperactive, but the knee jerks and Achilles' reflexes were definitely hyperactive. The plantar reflexes were negative. There was no ankle clonus. A few drops of pus were aspirated from the most tender area on January 8. The culture revealed hemolytic Streptococcus aureus. A cisternal puncture on January 8 revealed 233 cells and a trace of globulin. The rectal temperature on admission was 101.6 F., pulse 126, respiration 26. The leukocyte count was 15,000, and the hemoglobin was 10.5 mg. A roentgenogram of the spine was negative.

Diagnosis: Osteomyelitis of the spine.

Treatment: On January 8, the patient received sulfadiazine on the basis of 1 grain per pound of body weight per day. On the evening of the third day in the hospital, she passed gross blood in the urine, which subsided immediately when the dose was reduced one-half. A superficial abscess over the third lumbar vertebra was incised on the tenth day and continued to drain for three and one-half months. One month after admission, the dosage of sulfadiazine was again reduced in an attempt to maintain a blood level of 3 to 7 mg. for an additional three months. On the third day in the hospital, she received a transfusion of 200 cc. and on the fourth day 500 cc. of citrated blood. A roentgenogram on January 21 revealed an osteomyelitis of the spinous process of the third lumbar vertebra. She was discharged from the hospital on January 24.

Summary of Case: This patient developed a hematuria probably due to the large doses of sulfadiazine. The hematuria cleared up immediately when the dose was cut in half. The abscess was incised immediately after the acute stage and drained for three and one-half months. Clinically, this patient has made a complete recovery.

Case 3. C. B., a 4 year old girl was admitted to St. Luke's Hospital on January 21, 1942. According to the father, the patient had struck her leg on a door four days prior to admission. Two days later she complained of pain in the left ankle. Past history is inconsequential.

Examination: This child had the typical appearance of a person with an acute pyogenic infection. The lower one-third of the left leg was swollen. The ankle was slightly enlarged, but it could be moved slowly without much discomfort. There was local heat and tenderness about the lower end of the tibia. The rectal temperature on admission was 102.6 F., pulse rate 128, respiration 30. Blood culture taken on January 22 revealed hemolytic Staphylococcus aureus.

A roentgenogram on admission was negative.

Diagnosis: Acute osteomyelitis of the left tibia. A roentgenogram on February 2 revealed an osteomyelitis of the left tibia.

Treatment: Even though the patient received sulfadiazine on the basis of 1 grain per pound of body weight per day beginning January 22, the blood level on January 23 and 24 was only 3.5 and 5.3 mg., respectively, per 100 cc. On January 26, it was 10 mg. On the fourth day she began to show some improvement. During hospitalization the sulfadiazine dosage remained the same, but the following two months an attempt was made to keep the blood level between 3 and 7 mg. per 100 cc. A superficial abscess just below the knee was drained on January 31. It was completely healed one month later at the time the cast was removed. She was discharged from the hospital on February 7.

Summary of Case: This case was unusual in that even though large doses of sulfadiazine were given, the blood level did not rise above 5.3 mg. per 100 cc. until the third day. The abscess was incised when the temperature was practically normal, and it was completely healed in less than four weeks. Clinically, she has made a complete recovery.

Case 4. R. E., a boy aged 2 years and 4 months, was admitted to Milwaukee Children's Hospital on April 24, 1942. According to the mother, the child had had impetigo for several months. He had complained of pain in the left leg for one week. Past history was of no significance.

Examination: This patient did not appear acutely ill. The lower one-half of the left thigh presented some swelling. It was difficult to localize the tenderness. The rectal temperature on admission was 103 F., pulse 135, respiration 25. Blood culture on two occasions was negative. Throat culture revealed hemolytic Streptococcus. The leukocyte count was 21,300, the erythrocyte count 4,450,000, and the hemoglobin was 10.5 mg. A roentgenogram of the femur was negative.

Diagnosis: Acute osteomyelitis of left femur.

Treatment: Sulfadiazine on the basis of 1 grain per pound of body weight was given immediately on admission. The dosage was reduced by one-half after fourteen days of hospitalization. Because of a rising temperature, five days later a full dosage was again given for an additional ten days. Following this, the patient received one-half the full dose for a period of two months. A transfusion of 200 cc. of citrated blood was given on May 16 and again on May 19. Russell's traction was applied on

admission to the hospital. A roentgenogram on May 2 revealed an osteomyelitis of the left femur. He was discharged on July 28.

Summary of Case: In spite of large doses of sulfadiazine, the temperature remained elevated for two weeks. After subsiding for just two days, it again rose for a period of ten days. Clinically, the patient has made a complete recovery.

Summary of Treatment

1. Sulfadiazine should be given immediately on the basis of 1 grain per pound of body weight per day. This dosage may be safely increased to 1½ grains for several days.

2. The optimum blood level should range between 7 and 12 mg. per 100 cc. during the acute stage.

3. As soon as the temperature has subsided, the dose may be decreased to ½ grain per pound of body weight per day.

4. In a month or six weeks after the onset of treatment, the dosage of sulfadiazine may again be decreased. A blood level of 3 to 7 mg. per 100 cc. should be maintained for an additional three months.

5. As a safeguard while giving large doses of sulfadiazine, a complete blood count, urinanalysis, and sulfadiazine blood level are indicated every other day.

6. The fluid intake should be charted daily. Concentrated urine favors the formation of urinary sulfadiazine crystals.

7. Repeated small transfusions and intravenous dextrose are of considerable benefit.

The Treatment of Painful Feet*

How to Meet the Problem

By ROBERT P. MONTGOMERY, M. D.
Milwaukee

R. P. MONTGOMERY

Dr. Montgomery received his M. D. degree from the University of Michigan Medical School, Ann Arbor. He is a member of the American Board of Orthopaedic Surgery, the Clinical Orthopaedic Society, the American Academy of Orthopaedic Surgeons, and the American College of Surgeons.

FATIGUE is the most common cause of foot strain. Rapid growth, overweight, overwork, excessive responsibilities, chronic infections, and convalescent periods following operations and diseases are frequently accompanied by fatigue. When the muscles of the legs become tired from overuse or as part of a generalized fatigue, the support of the arches is lessened, and there is increased strain upon the ligaments holding the bones of the foot in an arch formation. These ligaments become stretched, painful, and tender and allow the arch of the foot to flatten. When the arches are flattened, the individual walks with his feet "turned out," and this gait places abnormal pressure on the balls of the feet. The forefeet soon broaden, the toes claw, and corns and calluses develop as a result of increased pressure against various parts of the shoes.

Development of Foot Muscle Strength

The object of treatment is to correct as far as possible the above causes for fatigue and to lessen the strain on the feet by proper use of the feet in walking and standing. If the feet are used in a normal heel-toe gait with the feet pointing straight ahead, the muscles supporting the arches will be strengthened as the feet are used. Temporary aids, such as adhesive strappings, padding inside of the shoes, and alterations on the outside of the shoes, are sometimes necessary. As the abnormal positions of the feet are corrected, the calluses and corns disappear without other treatment. Although

* Presented before the One Hundred First Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1942.

built-in and removable rigid arch supports relieve strain on the ligaments of the arch and lessen pain temporarily, they cause further weakness of the muscles that support the arch because the supports are doing the job the muscles should be doing and permit no exercise for the muscles. Without exercise and work, the muscles become progressively weaker. Such supports have limited use by aged people. Rarely are they indicated for use by children, because muscle strength in the foot should be developed by exercise in the process of correct walking. A flexible shank shoe permits normal use of the foot, and a rigid shoe hinders it.

More Foot Disorders in Women

Women's dress shoes are of necessity rigid-shanked because of the high heels used for style conformity. The rigid shanks and the high heels are conducive to foot strain and to the numerous associated foot complaints as indicated by the high incidence of foot disorders in women as compared to men. Style will control the choice of dress shoes, but there is no ruling conventionality that prohibits the use of attractive, low-heeled, flexible-shanked shoes for use in the home and in ones immediate neighborhood.

Aids For Painful Feet and Legs

Acutely painful feet and aching leg muscles can be readily relieved by relaxation in a tub of warm water for one or two minutes followed by elevation of the legs above the water level for a similar length of time. Five to ten changes in position are usually adequate. An additional aid can be easily added by voluntarily dorsiflexing the feet, bending the toes toward the soles of the feet and at the same time turning the soles of the feet towards each other while the legs are elevated. These positions should be maintained throughout the two minutes period of elevation. They assist the position of elevation and the coolness of the air against the moist skin in driving the blood from the muscles and, by so doing, allow a greater volume inflow of blood when the legs are relaxed. This rapid exchange of large quantities of blood into and out of the tired leg muscles in the form of vascular massage is very comforting.

Sometimes, but rarely, developmental abnormalities and other complicating factors of foot strain require such treatments as manipulations under anesthesia, the wearing of plaster casts, and operations.

HOSPITAL PATIENTS TO BE GRANTED SUPPLEMENTAL FOOD ALLOTMENTS

While the wartime need of conserving rationed foods is great, no hospital patient need suffer from inability to get foods required for his health, the Office of Price Administration said today.

The OPA is sending specific instructions highlighting this point to all local War Price and Rationing Boards, and to other OPA field offices. For several months, OPA and medical authorities have been studying the hospital problem with a view to developing a uniform procedure covering the granting of supplemental allotments for hospitals. Solution of the problem is believed near.

"In the meantime," OPA said, "a provision in the regulations (Section 11.6 of General Ration Order 5) should enable hospitals to obtain the necessary supplemental allotments so that no patients shall suffer from dietary deficiency. This provision gives local boards authority to grant such allotments to meet the dietary requirements of patients living in, and receiving care in, hospitals, whether or not such patients are on special diets.

"In determining the amount of the supplemental allotment of processed foods and the commodities covered by Ration Order 16, the local board will take into consideration the availability of fresh fruits and vegetables, unrationed substitutions such as poultry and fresh fish, and the physical facilities of hospitals to process and store such foods."

Administrative officers of hospitals had complained that local boards in some cases had confined the granting of supplemental allotments to situations covering patients on special diets.

"Section 11.6 of the ration order does not limit the granting of relief so narrowly," OPA explained. "No hospital patient need suffer from inability to get food because of rationing."

Comments on Treatment

Editors—A. J. QUICK, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Treatment of Syphilis

Notwithstanding the enviable record of the State of Wisconsin in attaining top rating as to the eradication of syphilis, a recrudescence is almost certain to appear in the near future in spite of the vigilance of the medical profession and the collaboration of the State Board of Health. This predicted increase is to be anticipated, since a sharp rise has already appeared in a number of the large cities in this country. It is pertinent, therefore, to survey briefly current and newer methods of therapy.

The wise general practitioner will forego the dramatic appeal of de Kruif in his much advertised article in the *Reader's Digest*. It may be that after a five or ten year period of observations, this "One Day Treatment" will have been established as practicable, but that time is not now. Even the "Five Day Treatment" appears doomed to modifications in view of the known acute mortality rate. Eagle has pointed out that a spread in the times of administration of the total dose of an arsenical, such as mapharsen, increases in safety almost in proportion to this spread. Thus, the dosage recommended by Chargin and associates to be given in five daily installments becomes safer if divided into ten or into twenty installments. The intervals between injections can vary from one to seven days with little evidence of diminished efficiency. However, a significant decrease in toxic reactions appears with use of the longer intervals.

Experimentally and clinically, fever therapy concurrent with specific chemotherapy does seem to lead clearly to a rapid clearance. However, the fever therapy alone has led to some extremely serious reactions which are further complicated, even aggravated, if antisyphilitic drugs are given at the same time. Consequently, we must consider this ultra new mode of therapy as purely experimental until such a time as it can be properly evaluated and so modified as to eliminate largely the hazards.

Becker of Chicago and Astrachan of New York are, and have been, advocates of the "concurrent" rather than the "block" system in the use of arsenic and bismuth. These opinions come as a clinical confirmation of laboratory experimentation in which it was demonstrated by my associates and me that arsenic and bismuth are quantitatively additive in toxicity to the spirochetes but clearly less so for the rabbit, the host to the infection. Thus, 50 per cent of the minimal curative dose of arsenic given simultaneously with 50 per cent of the minimal curative dose of bismuth amounts to a 100 per cent curative combination. However, it required the coaction of from 75 to 85 per cent of the minimal lethal doses of arsenic and bismuth to lead to a lethal toxic action on the host. This means that a higher spirochetal activity can be attained by the concurrent use of these two agents without harm to the host than if either drug be given alone as in the standard "block" system. It would seem, therefore, that giving a patient a rest from arsenic or from bismuth also rests the spirochete, and in neither instance is such a rest generally necessary or desirable.

As to choice of therapeutic forms of arsenic, mortality rates from antisyphilitic arsenicals clearly give the answer in favor of the arsenoxide of arsphenamine, which is available under the form of mapharsen. Dichlorarsene, recently introduced, yields the same oxide as soon as it is dissolved in watery solutions.

Regarding bismuth preparations, we must repeat our long time teaching that "bismuth is bismuth regardless of how it is dressed up in the molecule." The only clearly recognizable difference among the various forms of bismuth available for therapeutic use is that in the rate of absorption from the intramuscular deposits. The salicylate is quite

slowly absorbed, whereas the tartrate and a number of other salts of bismuth are more rapidly absorbed. Aside from these differences in the rate of absorption and the consequences thereof, there appears to be no basically significant difference among the various commercial preparations.

As to the administration of bismuth orally, it is to be remembered that bismuth is absorbable from the gastrointestinal tract, as demonstrated earlier by the use of bismuth subcarbonate for other purposes and more recently by the use of sobisminol. If one could be sure of the rate of absorption from the intestine, there would be no theoretic reason for not giving bismuth orally; however, the rate of absorption of most substances from the gastrointestinal tract varies enormously from time to time and from patient to patient. With intramuscular administration, these differences are greatly reduced and are exceeded only by intravenous injections, which are entirely out of the realm of safety for human therapy. A. L. T.

Why Should Cancer Cases Be Reported?

By WILLIAM C. KEETTEL, M. D.
Wisconsin State Board of Health
Madison

THE busy physician no doubt wonders why he should be burdened with more "paper work." He can see the value of reporting a contagious disease, because in such a case a diagnosis in one individual is sufficient to set in motion the need for a definite train of preventive measures for others in the community. At first it may be difficult for some to visualize the rationale of cancer reporting.

The reason for cancer reporting is to gather factual information, which is necessary for any cancer control program. It is not enough to know that cancer is the second cause of death in Wisconsin or that cancer deaths are increasing. Cancer control is such a complex problem that we must have every bit of available information. The close cooperation of the medical profession, public health agencies, medical schools, hospitals, and interested lay groups is essential in collecting this data.

The mere reporting of cancer cases will not prevent cancer deaths; it will only furnish the necessary basic information needed to determine the extent of the problem and to act as a guide in future planning. Accurate and complete reporting will aid in answering such important questions as the following:

(1) The true magnitude of the cancer problem.

(2) The relative incidence of cancer by ages in the various sections of the state and among various social and economic groups.

(3) The relation between cancer and such factors as occupation and race.

(4) The effectiveness of the lay educational programs.

(5) The true incidence of the various forms of cancer.

(6) The method of treating the various types of malignancy.

(7) The accuracy of mortality statistics.

The ground work has already been carefully laid in Wisconsin. Cancer has been made a reportable disease. A simple, complete reporting card was devised after careful study and was approved by The Committee on Cancer of the State Medical Society. Figure 1 illustrates the front of the cancer reporting card. In reporting cancer cases, it is essential that the name of the patient be given so that duplicates can be eliminated. The physician need not fear that confidential information will be divulged, as these reports are not open to public inspection. The questions concerning race, residence, and occupation were designed to determine if these conditions influenced in any way the various types of malignancy reported in Wisconsin. Figure 2 illustrates the reverse side of the card. The first five items give very valuable data concerning the effectiveness of the present educational program.

Malignancy control is an extremely important health problem; what can be done to save the life of an individual with cancer is

of importance to every physician. We have failed in making cancer reporting a success in Wisconsin. Since this is a prerequisite of any successful cancer control program, it deserves the whole-hearted support of every Wisconsin physician.

Wis. Statutes
Sec. 140.05

WIS. STATE BOARD OF HEALTH
MALIGNANT-NEOPLASM REPORT

No. _____ Do not fill in

This Report is Confidential

Patient's Name | Address

Age | Sex | Race | Single | Widowed | Married | Divorced | Total Children: Born Alive M F | Still-born M F | Now Living M F

Country of Birth | Years in U. S. | Years in Wis. | Localities in Wis.

Birthplace of Patient's Father | Birthplace of Patient's Mother

Patient's Present Trade or Occupation | Years in Occupation

Particular Nature of Duties

Other Occupation in Past Ten Years | Duties

Type and Description of Neoplasm

Primary Organ or Site | Metastasis to

OVER

Fig. 1. Front of Cancer Reporting Card.

Date Growth Suspected by Patient | Date Growth Suspected by Physician

Date of First Diagnosis | Date of First Treatment

Type of Treatment Received

Patient's First Operation for Malignant Growth

Date | Recurrence | Date

Diagnosis { Clinical / Microscopic

Remarks

Physician Reporting | Address | Date of Report

THIS CARD APPROVED BY THE CANCER COMMITTEE OF THE STATE MEDICAL SOCIETY

Fig. 2. Back of Cancer Reporting Card.*

* Additional reporting cards can be obtained from The Wisconsin State Board of Health, Madison, Wisconsin.

The Nation at War

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Recent Amendments to Food Rationing Meet New Needs

Recent amendments to food rationing orders, involving condensed milk, fats, oils and hospitals, are summarized in *The Journal of the American Medical Association* for July 17 as follows:

Food rationing regulations provide that a person whose health requires more rationed food than his ration points permit him to buy may apply to his local board for necessary additional points. In some illnesses foods are prescribed in addition to drugs or medicines, or as a substitute for them. In some counties the work of ration boards in processing such applications has been much simplified through the voluntary help of the doctors themselves. By establishing panels to review all medical certifications and to advise the boards, responsibility for issuing extra rations for health reasons has been kept on a professional level.

The Office of Price Administration under date of June 1 placed evaporated and condensed milk on the list of rationed products. These types of milk are added to the group of rationed foods containing meats and fats, for which red ration stamps are needed, without any increase in the total number of points allowed for this group. One point is required for one 14½ ounce can or for two 6 ounce cans or for two 8 ounce cans. This means that the child may use 7 of his 16 points per week for his milk requirements in terms of evaporated milk, which allows slightly less than the equivalent of a quart of whole milk per day, and have 9 points remaining for his meat and fat requirements. An invalid or any other person whose health requires that he have more canned milk than he can obtain with the stamps in his War Ration Book II may apply at his local War Price and Rationing Board for additional points. The consumer must submit a written statement of a licensed physician showing why he must have more canned milk, the amount needed during the succeeding two months and why unrationed foods cannot be used instead. A supplemental allotment to acquire canned evaporated and condensed milk needed by a hospital to meet the dietary needs of its patients may be obtained on application to its local War Price and Rationing Board. It is understood that, if the present method of rationing does not make evaporated milk available in all areas for infants and children, some more effective method will be worked out.

The Office of Price Administration has issued an amendment to ration order number 16 (R. O. 16, amendment 25) which permits the use of rationed fats and oils for external therapeutic purposes. This includes the use of vegetable oils, such as cottonseed oil, for bathing newborn infants, for external application in skin diseases, for urethral injection or lubrication of urethral instruments, and for x-ray visualization. Such use of rationed fats and oils is defined as "industrial consumption" and persons using these products for such purposes are classified as "industrial consumers." An industrial consumer engaged in the care and treatment of the sick and needing rationed fats and oils for this purpose may apply to his district Office of Price Administration for a certificate with which to acquire them. The procedure to be followed, briefly, is as follows: The application should be made on form R-1605 to the district office. If the applicant is a hospital the district office will pass on the application by using the same method of computing allowances as the local boards use in computing allotments for industrial users; otherwise the application will be forwarded to the Washington office for action. If the applicant requires more than he would receive by the method of computation described, he should also submit form R-315 stating the reasons for such request. An "industrial consumer" to whom a certificate is issued for "industrial consumption" of rationed fats and oils may use it only to acquire the foods for which application was made and may use those foods only for the purpose for which the application was granted.

For several months the Office of Price Administration and medical authorities have been studying the hospital problem with a view to developing a uniform procedure covering the granting of supplemental allotments for hospitals. Solution of the problem is believed near. In the meantime a provision in the regulations (section 11.6 of general ration order 5) should enable hospitals to obtain the necessary supplemental allotments so that patients need not suffer from dietary deficiency. This provision gives local boards authority to grant such allotments to meet the dietary requirements of patients living in and receiving care in hospitals whether or not such patients are on special diets. In determining the amount of the supplemental allotment of processed foods and the commodities covered by ration order 16, the local board will take into consideration the availability of fresh fruits and

vegetables, unrationed substitutions such as poultry and fresh fish, and the physical facilities of hospitals to process and store such foods.

Military Notes

Dr. Lloyd F. Sherman, who has been a practicing physician in Siren during the last four years, recently reported at the Great Lakes Naval Training Station to start his duties in the armed forces. He joined the navy last February.

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Lieutenant Gordon E. Carroll notifies us of his change in location to the United States Naval Air Station at Norman, Oklahoma. He writes, "We are very proud of our Society and its consideration of the men in service. Many of the men down here from other states have commended our Society very highly." Lieutenant Carroll formerly practiced at Laona.

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In a communication from **Lieutenant Colonel Leo W. Peterson,** formerly of Sun Prairie, the work of the home front physician, as well as that of the Society, is commended as follows: "Your news letter of October 7, 1942, reached me a few days ago. Needless to say, I was happy to receive it. It gave me many interesting news notes on the members of the Society and some side lights of the state meeting. Keep up the good work. Your Society is surely doing a lot of work and benefit for those gone into the service. It is a genuine good feeling to know that the members on the home front are doing so much more to keep up the standards of the medical profession and still keep up the standards of the medical service so that many obnoxious movements and legislation against the medical profession do not gain a foothold. Many thanks and praises to those members on the home front."

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Two former members of the staff of the Adams-Friendship Hospital, **Captain Harry Shapiro** and **Lieutenant A. J. Harris,** recently were on leave in Adams at the same time and were able to enjoy a visit together. Captain Shapiro is stationed at Fort Snelling, Minnesota. Lieutenant Harris is in service with the Marines and has been located in the Pacific war area.

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Lieutenant Commander I. J. Ricciardi, Milwaukee, who has been stationed at the naval officer procurement headquarters in Milwaukee for the last three years, was recently advanced from the rank of lieutenant.

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According to press reports, the modern American hospital which rises out of the dense jungles of New Guinea is like a miracle of the war. The hospital is the work of an army medical unit headed by **Colonel William J. Bleckwenn,** formerly a professor of neuropsychiatry at the University of Wisconsin for twenty years. The unit undertook the New Guinea project after building two fully equipped hospitals in an isolated district of northern Australia.

According to Colonel Bleckwenn, one of the main reasons why the hospital is of such excellent quality is the fact that the building unit included many plumbers, tinsmiths, mechanics, and northern Wisconsin lumbermen.

The use of makeshift materials in the construction of the hospital is an example of the amazing ingenuity being shown among our medical forces on the fighting front. Sinks were made from steel barrels cut in half, and sewage pipes, from discarded shell cases. An old delousing machine was used to pipe steam into wash messkits, which amazingly slashed the number of cases of dysentery. The sawmill which turned out lumber for the hospital project was constructed from a wrecked plane, two abandoned trucks, a worn out tractor, and parts from a copper mine. Jeeps were remodeled as ambulances, and fracture tables were built of discarded pipe and navy hammocks. The "assembly line" layout of surgical tables which was set up has enabled anesthetists, surgeons, orderlies, and interns to handle patients far more rapidly than under ordinary circumstances. Many patients have been operated on during bombing raids.

The building project was begun February 3 and was accommodating patients within four months. The staff members, many of whom are Wisconsin men, built their own living quarters, tents, and wooden huts. The chief chaplain of the hospital lauded the unit for working hard with picks and shovels, saws and hammers, to build the finest medical center the Army has in the southwest Pacific.

Because a hospital must be not only a medical care center but also a nerve relaxing center for the soldier patients, it has even an outdoor theater, which seats 1,500 persons, and a band shell. Entertainment for the patients and the staff includes band concerts, productions by a dramatic society, movies, a library, and a reception hall.

Although the whole cost of the hospital to the United States was for some lumber, tin, and nails, yet the building is valued at approximately $10,000, states Colonel Bleckwenn.

Among the Wisconsin men comprising a part of this unit are the following physicians who formerly practiced in various Wisconsin cities: **Captain Leo B. Perssion,** Winnebago; **Major Robert Baldwin,** Marshfield; **Captain Robert Waffle,** Fond du Lac; **Major Edwin P. Ludwig,** Wausau; Major James E. Miller, Madison; Lieutenant Colonel Marc J. Musser, Jr., Madison; and Captain John R. Peterson, Milwaukee.

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Captain Lloyd F. Kaiser, formerly of Rhinelander, writes that he is receiving the *Journal* in good time and that it is always appreciated. Captain Kaiser's family is residing in Mt. Vernon, Illinois, for the duration. His A.P.O. address is San Francisco.

Writing from Ft. Sheridan, Illinois, **Captain Kermit W. Covell, Racine,** says that he finds it most interesting to hear of the proceedings of the Society and the work which has been done in behalf of members of the medical profession.

Since the time of his letter, Captain Covell has been transferred to the Aviation School of Medicine at Randolph Field, San Antonio, Texas, for a course in aviation medicine.

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Lieutenant Paul S. Herzog, Kenosha, is now stationed at Randolph Field, Texas. Speaking highly of his assignment at "the West Point of the Air," he states: "The spirit and morale here are very high and would encourage the civilians very much. My work is of a routine nature, inasmuch as I am assigned to a dispensary."

Lieutenant Herzog met **Lieutenant W. A. Hilger,** formerly of Milwaukee, while he was taking the course for medical officers at Carlisle Barracks, Pennsylvania.

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Located at the Naval Air Training Center, Pensacola, Florida, **Lieutenant Emil Franklin,** Milwaukee, is at present taking the course in aviation medicine leading to the title "Aviation Medical Examiner." He says that he can earn his "wings" later by putting in the necessary flying time and then becoming a flight surgeon.

Of the *Journal* he states, "I think it needless for me to say how much I enjoy receiving it and reading all the articles and personal news."

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Captain J. Rouse, Hillsboro, likes his new assignment in the surgical service at the Station Hospital, Camp Wolters, Texas.

Captain Rouse enjoys the *Journal* very much, especially the Military Notes section.

—△—

Commander James C. Sargent, Milwaukee, was granted a leave from his duties at the United States Naval Training Station, San Diego, California, to attend the annual meeting of the House of Delegates of the American Medical Association at Chicago as a delegate from the State Medical Society of Wisconsin.

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Captain Gunnar D. Quisling, Madison, has turned over to the United States government two inventions which may prove invaluable toward winning the war, according to the Public Relations Office, Camp Stewart, Georgia. For the time being, the inventions must remain a secret.

Captain Quisling is chief of the eye clinic of Camp Stewart. His late father, Andreas Quisling, was a brother of the Norwegian Quisling's father and came to America fifty years ago. The army captain said that he met the Norwegian traitor in 1931 during a visit to Norway. He believes that the fact that Vidkun Quisling was married to a Czarist Russian was largely responsible for his becoming a tool of the Nazi government.

Armed Forces Must Have 6,000 More Physicians By January 1

Journal of A. M. A. Calls on the Profession to Meet Fully the Responsibility That Has Been Placed on it

The armed forces must have 6,000 additional physicians by Jan. 1, 1944, *The Journal of the American Medical Association* reports in an editorial in its August 7 issue. *The Journal* says:

"At a conference of the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians, held on July 31, with the War Participation Committee of the American Medical Association and in the presence of Mr. Paul V. McNutt, chairman of the War Manpower Commission and representatives of the Army and Navy medical departments and the Public Health Service, it became apparent that the medical profession must produce toward the winning of the war an additional six thousand physicians for the armed forces before Jan. 1, 1944. Pursuant to a realization of this objective a directive has gone to the generals in command of the various service commands authorizing them to induct into the service physicians between the ages of 38 and 45 who have been declared available by the Directing Board of the Procurement and Assignment Service for Physicians, Dentists and Veterinarians and who are otherwise subject to Selective Service.

"The needs of the armed forces are real. The members of the War Participation Committee raised with the representatives of the various governmental agencies all the questions that have from time to time challenged the need; the challenge seems to have been met effectively. Indeed, the intimation was made clear that the needs of the armed forces will be met by specific regulations of the Selective Service Administration or the enactment of necessary legislation if required. All physicians up to 45 years of age who have been indicated as available have therefore placed on them now the responsibility for an immediate decision as to their enlistment with the armed forces. The need is so positive that questions of essentiality of men in positions of teaching and research and in industrial medicine are likely to be rigidly reviewed in the near future with a view to extracting from civilian life every one that can be spared.

"As the war continues and intensifies new needs for the services of the medical profession become apparent. An army in motion and one engaged in the kind of aggressive combat that now concerns our armed forces needs physicians in even greater numbers than have heretofore been demanded. Many thousands of interned aliens and prisoners are now the burden of the United States and must be given medical care.

"If there is any physician who still hesitates under these circumstances, he should realize the added advantage to him of accepting now the commission that is proffered. Should it become necessary in the near future, as seems quite likely, to enlist new activity by the Selective Service Administration and the Officers' Procurement Service to bring in the six thousand physicians that are so certainly required, those recruited by that technic will inevitably begin their service with the minimum commission that is offered, namely that of first lieutenant. Until that technic is installed, the men of special competence and of years beyond those of the recent graduate have the assurance of careful consideration and a commission more nearly in accord with age and experience.

"The call here made has the approval of the Directing Board of the Procurement and Assignment Service and of the War Participation Committee of the American Medical Association. The medical profession may well be proud of the fact that it has been the only group given, by directive of the President, the responsibility of maintaining service in civilian life and at the same time supplying the needs of the armed forces. Let us not fail in meeting fully the trust that has been placed upon us."

Wisconsin Physicians in Service*

Adams County

Harris, Arthur James, Adams
Shapiro, Harry, Adams

Ashland County

Ansfield, Fred J., Glidden
Harrison, G. W., Ashland
Seifert, K. A., Ashland
Weeks, F. D., Ashland

Barron County

Bensman, L. L.
Dawson, D. L., Rice Lake
Hatleberg, E. J., Rice Lake
Schlomovitz, H. H., Barron

Bayfield County

Regnier, W. C., Drummond

Brown County

Bolles, C. S., West De Pere
Denys, K. J., Green Bay
Goggins, J. R., Pulaski
Icks, K. R., Green Bay
Mokrohajsky, S. M., Green Bay
Saunders, O. W., Green Bay
Schilling, H. J., Denmark
Schoenenberger, A. P., Denmark
Schoofs, G. E., Green Bay
Troup, W. J., Green Bay
Weaver, D. F., Green Bay
Williamson, C. S., Green Bay

Burnett County

Johnson, P. A., Grantsburg
Sherman, L. F., Siren

Calumet County

Vande Loo, F. B., Brillion
Wagner, A. J., Brillion
Winkler, R. J., Hilbert

Chippewa County

Clauson, C. T., Bloomer
Henske, W. C., Chippewa Falls
Picotte, L., Chippewa Falls
Vaudreuil, W. F., Chippewa Falls

Columbia County

Brown, Harry E., Portage
Doersch, E. A., Portage
Dryer, R. B., Poynette
Ronneburger, E. O., Cambria
MacGregor, J. W., Portage

Dane County

Allin, R. N., Madison
Atwood, D. C., Madison
Axel, B. J., Madison
Barnstein, Norman, Sun Prairie
Bell, John L., Madison
Bennett, A. P., Madison
Bentley, J. E., Madison
Bingham, J. B., Madison
Birge, E. A., Madison
Bleckwenn, W. J., Madison
Bohorfoush, J. G., Madison
Boner, A. J., Madison
Brindley, B. I., Madison
Britton, D. M., Madison
Brooke, J. W., Madison
Brownfield, J. D., Madison
Connor, J. J., Madison
Cunningham, P. M., Madison
De Salvo, M. F., Madison
Dietrich, H. W., Madison
Dollard, J. E., Madison
Ellingson, H. V., Madison
Fosmark, C. A., Madison
Gale, J. W., Madison
Gearhart, R. S., Madison
Geist, F. D., Madison
Gordon, E. S., Madison
Greiber, M. F., Madison
Halbert, J. J., Madison
Hawk, M. H., Madison
Jackson, Russell, Madison
Jacobsen, R. W., Madison
Joachim, F. G., Madison
Johnson, H. C., Madison
Jones, W. E., Madison
Jorris, E. H., Madison
Kanzler, Reinhold, Madison
Keck, E. B., Madison
Knecht, E. M., Madison
Kohler, H. H., Madison
Lappley, W. F., Madison
Larsen, R. B., Madison
Leede, W. E., Madison
Lemmer, K. E., Madison
Marshall, F. S., Chicago
MacKenzie, J. G., Madison
McCormick, D. W., Madison
Malec, J. P., Madison
Meyer, B. W., Madison
Middleton, W. S., Madison
Miller, J. E., Madison
Moore, R. M., Madison
Musser, M. J., Madison
Myers, M. A., Madison
Nellen, J. W., Madison
Nelson, E. R., Madison
Oosterhous, G. E., Madison
Orr, E. R., Madison
Peabody, C. S., Madison
Pessin, Joseph, Madison

* As of July 20, 1943.

Peterson, L. W., Sun Prairie
Pohle, F. J., Madison
Pyre, Jackman, Madison
Quisling, G. D., Madison
Rendok, John, Madison
Reuter, R. J., Madison
Rogers, S. C., Madison
Rueckert, Raymond, Madison
Seastone, C. V., Madison
Shapiro, H. H., Madison
Sherman, C. F., Madison
Shulman, H. W., Madison
Sims, J. L., Madison
Smedal, A. T., Stoughton
Sprague, J. T., Madison
Swan, L. L., Madison
Wangeman, C. P., Madison
Wear, J. B., Madison
Weismiller, L. L., Madison
Weston, F. L., Madison

Dodge County

Bachhuber, E. A., Mayville
Bloom, C. S., Horicon
Hoyer, E. C., Beaver Dam
Kierzkowski, C. V., Beaver Dam
Pearson, J. B., Mayville
Qualls, C. L., Juneau
Temkin, M. M., Beaver Dam
Vetter, E. W., Randolph

Door County

Leasum, Charles, Sturgeon Bay
Little, W. W., Washington Island

Douglas County

Berg, G. S.
Christiansen, R. E., Superior
Christianson, H., Superior
Hathaway, G. J., Superior
Jerome, Bourne, Superior
Johnson, Fred, Jr., Superior
Leveroos, E. H., Superior

Dunn County

Buckley, C. H., Menomonie

Eau Claire County

Brown, G. F., Eau Claire
Culver, L. G., Eau Claire
Dickelmann, L. E., Eau Claire
Fuson, H. S., Eau Claire
Humphrey, N. R., Brandon
Ihle, C. M., Eau Claire
Kincaid, Charles, Eau Claire
Midelfart, Peter, Eau Claire
Mitchell, M. T., Eau Claire
Noland, O. G., Augusta
Niver, E. O., Eau Claire

Florence County

Cook, Alfred L.

Fond du Lac County

Calvy, D. W., Fond du Lac
Cole, D. F., Ripon
Dalrymple, R. R., Fond du Lac
Dana, R. L., Fond du Lac
Finn, W. C., Fond du Lac
Eagleburger, L. S., Waupun
Florin, A. C., Fond du Lac
Haseltine, C. P., Ripon
Hull, H. H., Brandon
Hutter, A. M., Fond du Lac
Jones, R. H., Ripon
Keenan, L. J., Fond du Lac
Kief, H. J., St. Cloud
Pawsat, E. H., Fond du Lac
Trier, P. J., Fond du Lac
Twohig, D. J., Jr., Fond du Lac
Waffle, R. L., Fond du Lac
Wier, J. S., Fond du Lac

Forest County

Carroll, G. E., Laona

Grant County

Glynn, J. D., Lancaster
Kelly, W. J., Potosi
Klockow, W. E., Muscoda
Moffett, J. L., Montfort
Schuler, W. H., Fennimore
Rempe, A. C., Cassville

Green County

Bear, N. E., Monroe
Bristow, J. H., Monroe
Brunkow, B. H., Monroe

Green Lake County

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« « « EDITORIAL » » »

See You at Milwaukee?

OF COURSE we'll see you in Milwaukee on Monday, Tuesday and Wednesday, September 13, 14 and 15, for the One Hundred Second Anniversary Meeting of the State Medical Society. Your presence, as well as that of every other member of the Society, is important. It is important this year more than ever before. It is of importance not alone to your State Society but of far more importance to your community and to you.

War medicine and the effect of war upon physicians, soldiers, and the civilian public will be especially emphasized. Outstanding officers of the medical corps of the Army, Navy, and Civilian Defense agencies of the country will be in attendance and will participate in the meeting. Among the topics to be emphasized that are of current and vital interest to the health of your community will be the discussion of "Medicine Here and in the Tropics," "Ulcer Problems in the Armed Forces," "Medical Education in the Armed Forces," "The Use of Blood Substitutes," "Complications of Sulfonamide Therapy," and "Medical Aspects of Chemical Warfare." Another war topic of concern to every community and every physician is the one entitled "A Contrast of Selective Service and United States Army Physical Examinations."

The importance and significance which the Army and the Navy place upon scientific sessions such as our Annual Meeting is evidenced by the appearance on the program of the Surgeon General of the United States Navy, Admiral Ross T. McIntire. Army and Navy officers have granted permission for the participation in the meeting of members of their medical staffs.

Over twenty-five leading physicians of the United States have consented to come to Wisconsin to make possible this wartime scientific session, men who have demands made upon their time that exceed by far the hours and the days that are available.

Your obligation to your community is such as to leave only one course of action open to you—that of attending the One Hundred Second Anniversary Meeting.

See you in Milwaukee? Of course we'll see you there.

. . . . THE PRESIDENT'S PAGE . . . .

A Blue Chip Investment

THE annual meeting of our State Society soon will be held in Milwaukee. A banner program has been arranged by our energetic and resourceful Council on Scientific Work. Attendance should be a "must" on your calendar. It will pay big dividends to you and your patients, since it is a blue chip investment of your time.

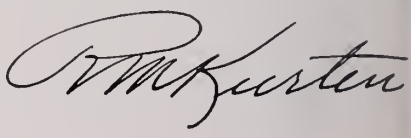
Being busy and the shortage of doctors on the home front are not valid excuses. We have pledged ourselves to give adequate care to the public while our confreres are performing a similar service, a truly glorious service, to the men and women in the armed forces. To be adequate, our medical care must be qualitative as well as quantitatively efficient. Keeping abreast of new developments and refreshed on established modalities in diagnosis and treatment is essential to maximum efficiency in a streamlined economy. Public health, especially industrial health, is our greatest fortress and ours to protect. Knowledge is our power. The public acknowledges our position and looks to organized medicine for its safety in matters of health. Our attendance at the annual meeting clinics is expected by our patients and justifies their respect for the institutions of organized medicine, which is the great disseminator of scientific accomplishment in the health field.

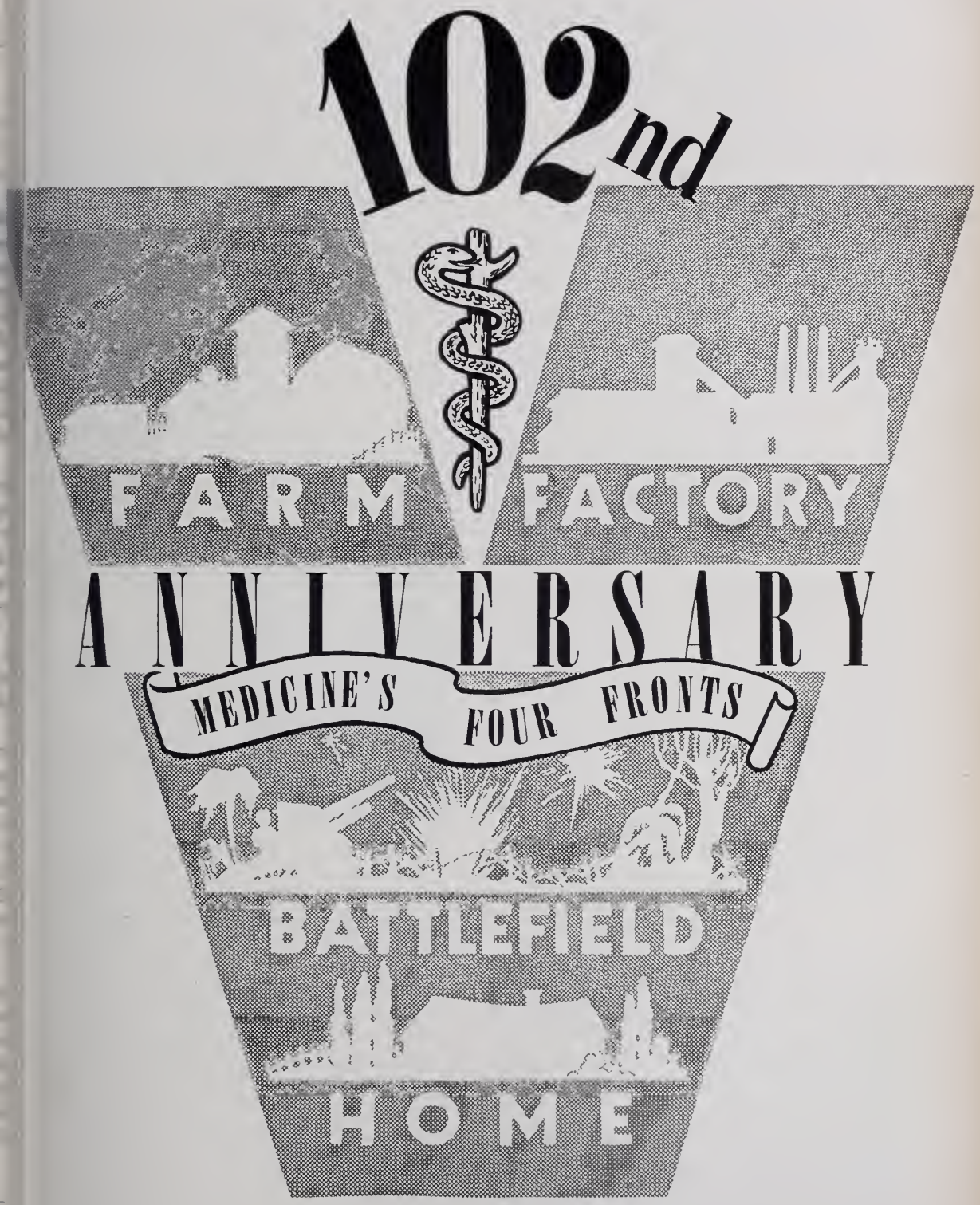
To the delegates I make this request: Study well the agenda and notes which you will shortly receive. Know the implications and ramifications of the proposed matters coming up for your decision. Only by having discussed the problems of current interest with your constituents can you know their attitude and truly represent them. Ours is a democratic system, and you, as delegates, the mouthpiece of those you represent; they have a right to be heard. Your background and foresight are essential in making our deliberations at the annual meeting of the House of Delegates a true accomplishment.

This meeting will be a vital one. The position of medicine in the future depends on the attitude and interest of physicians at the county and state level, since the national picture can be only the product of state desire for action or status quo. Wisconsin is looked to for sound and progressive leadership.

The success of our Society's sessions in the politico-economic realm of medical practice demands that there be no factions in the House. Only through the State Society can the national level be reached, since each county society is but a unit of the state organization. There are no problems presented at the session that do not concern each unit, because the destiny of one is the destiny of all. The larger societies have the strength of numbers and the accumulated wisdom of their group; both should be contributed to the common objective to keep medicine serving public health at its greatest efficiency. The small societies are given prestige and strength through such unanimity. United, we present a powerful influence socio-economically and politically. Broken up into factions, we become a hapless scapegoat of public derision.

Therefore, all delegates, be present at all of the sessions, be heard, be medical statesmen working for the common welfare of organized medicine. Forget your county lines; you represent the State of Wisconsin. Medicine is a troubled world in perilous times. Your objective should be only to keep medicine on a high plane so that our colleagues returning from far-flung battle fields will find a profession and a public united in acclaiming medicine for its valiant service in keeping social change and progress consistent with private practice and individual initiative yet espousing that which is necessary to make social extensions applicable to our art and science.




102nd
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MEDICINE'S FOUR FRONTS
BATTLEFIELD
HOME

Medicine's Four Fronts Will Be Stressed at the One Hundred Second Anniversary Meeting

MEETING DATES
Monday, September 13
Tuesday, September 14
Wednesday, September 15

THE responsibility of maintaining the health of our armed forces, industrial employes, farm families, and all persons on the home front falls to the lot of the medical profession. Physicians from private practice have entered the armed forces to provide the military personnel with the needed care.

The Army and the Navy

High ranking officers of the United States Army and Navy will bring to Wisconsin timely and critical information. Rear Admiral Ross T. McIntire, Surgeon General of the United States Navy, will discuss "Preparation of Physicians for the Armed Services." The personal representative of Major General Norman T. Kirk, Surgeon General of the United States Army, will report on "Medical Observations from the South and Southwest Pacific." In addition, Captain W. E. Eaton, Medical Officer in Command at Great Lakes; Major C. S. Higley, Chief of Medical Service, Truax Field, Madison; Major John A. Grab, United States Selective Service; and John S. Coulter, Regional Medical Officer of the Sixth Civilian Defense Region, will participate in the program.

War Topics

While many of the topics to be discussed have both a military and a civilian application, those topics which will be discussed with specific reference to war and its relationship to medicine are: "Surgical Advances from the War," "Psychiatric Problems Arising from Military Service," "Treatment of Patients Suffering from Wounds due to Poison Gas," "Emotional Disorders and Selective Service," "Soldier's Heart," "Medical Aspects of Chemical Warfare," "A Contrast of Selective Service and United States Army Physical Examinations," "Tropical Medicine Here and in the Tropics," "Ulcer Problems in the Armed Forces," "Medical Education and the Armed Forces," and "The Practice of Medicine After the War."

Annual Dinner

Assurance is given that the topics to be discussed at the annual dinner, which will be held on Tuesday evening, September 14, in the Crystal Ballroom of the Hotel Schroeder, will be of intense interest to both physicians and their wives. Russell M. Kurten, president of the Society, has been fortunate in obtaining the president of the American Medical Association, Dr. James E. Paullin, who will discuss "The Role of the Medical Profession in Planning for Postwar Medical Service." In addition, the personal representative of Major General Norman T. Kirk will at this time discuss "Medical Observations in the South and Southwest Pacific." We are unusually fortunate in obtaining for a dinner meeting of this character such outstanding speakers to present timely, informative, and highly interesting material such as that which is outlined for this annual event. While those who are scheduled to be seated at the speakers' table will be formally attired, members of the Society and their wives will appear in business suits and street dresses.

JAMES E. PAULLIN

Scientific Program

The scientific program is in a true sense a planned program. The choice of subject matter and of those who have been selected to present it has not resulted from chance, but a studied effort has been made to organize an integrated program by first selecting the subject matter then obtaining speakers best able to present the material. Two symposiums have been arranged by Dr. Francis D. Murphy, who was assigned the active preparation of the scientific program under the direction and supervision of the Council on Scientific Work. One symposium is devoted to a discussion of peptic ulcer, and the other symposium relates to the liver.

F. D. MURPHY

Sectional Programs

In addition to the general sessions which will be presented throughout the day on Monday and Tuesday and during the afternoon Wednesday, there will be held on Wednesday morning the several sectional meetings designed to be of particular interest to the various groups of specialists. The programs for the sectional meetings were prepared by their chairmen and approved by the Council on Scientific Work. Members of the Society whose responsibility it was to prepare these programs are listed below together with their respective sections:

Section on Internal Medicine and Cardiology—Alvin G. Koehler, Oshkosh

Section on Obstetrics and Gynecology—Robert L. Cowles, Green Bay

Section on Ophthalmology—William E. Grove, Milwaukee

Section on Orthopedics—Robert E. Burns, Madison

Section on Pediatrics—Henry A. Sincock, Superior

Section on Radiology—Lester W. Paul, Madison

Section on Surgery—Dexter H. Witte, Milwaukee

Section on Urology—Walter M. Kearns, Milwaukee

Section on Otolaryngology—William E. Grove, Milwaukee

Section on Hospital Relations

The Committee on Hospital Relations, which has for the last three years given close study to the relationship between physicians and hospitals, has secured the consent of the Council of the Society and the approval of the Council on Scientific Work for the presentation of a special section meeting on hospital relations. To this meeting will be invited chiefs of staff, hospital superintendents, members of hospital boards, and others interested in the relationship of physicians to hospitals. The chairman of the Committee on Hospital Relations, John E. Habbe, will act as chairman for the section meeting. Out-of-state speakers obtained for this section meeting are William A. O'Brien, Minneapolis; William A. Coventry, Duluth; Father Alphonse M. Schwitalla, St. Louis; and Mr. J. W. Holloway, American Medical Association, Chicago.

Members of the Society are urged to arrange for the attendance of the chiefs of staff with which they are associated and to extend an invitation to hospital board members, superintendents, and others who would be interested in the special program which has been arranged for this group.

Scientific Exhibits

Through the employment of three-dimensional exhibits, such as those that are to be presented at the scientific exhibit section, all of the sensory faculties used in transmitting information will be employed—visual, auditory, touch, and olfactory. Until recent years scientific exhibits were considered as the unwanted stepchild of postgraduate medical education. In recent years they have shed this aura and are now recognized as of comparable importance to the didactic lectures in conveying and portraying scientific information.

Through C. D. Neidhold, director of the scientific exhibits, the Council on Scientific Work has assured correlation with the general sessions program, and this correlation is evidenced by the development of scien-

tific exhibits which further emphasize the material presented at the general sessions. Included in the exhibits and in the general sessions will be "Tropical Diseases," "Diseases of the Liver," "The Gastrointestinal Tract," and others.

By demand of the members of the Society, the scientific exhibits have been increased. The largest number of exhibits ever to be shown at an Annual Meeting of the Society will be on display in the main arena of the Milwaukee Auditorium.

Secretaries' Conference

Preceding the initial meeting of the House of Delegates on Sunday, September 12, a Secretaries' Conference will be held at 2:30 p.m. at the Hotel Schroeder. To this meeting will be invited the presidents, secretaries, and trustees of the component county medical societies and the officers of the State Medical Society.

The conference will be presided over by President Russell M. Kurten. The topics scheduled for discussion are "The American Medical Association," "The New Council on Medical Service and Public Relations of the American Medical Association," "The State Medical Associations and their Relationship to the Component County Medical Societies," "The Use of Scientific Motion Pictures in a County Medical Society Program," and "The Trained Attendant Program in Wisconsin."

House of Delegates

The initial meeting of the House of Delegates will be held on Sunday, September 12, immediately following the termination of the Secretaries' Conference.

Members of the Society, whether delegates from their county medical societies or not, are privileged to attend the meetings of the House of Delegates and to be heard by them on vote of the House. The Speaker of the House of Delegates, Dr. Charles Fidler, Milwaukee, extends to each member of the Society a cordial invitation to attend all sessions of the House of Delegates. The initial meeting will be held on Sunday at 5:00 p.m., the second meeting at 6:45 p.m. on Monday, and the final session at 8:00 a.m. on Tuesday.

Obstetric Manikin Demonstration

Extensive preparations have been made by the Wisconsin Society of Obstetricians and Gynecologists to present in the scientific exhibit section an exhibit employing eminent teachers and demonstrators. At each mid-morning and mid-afternoon recess period, demonstrators will both discuss and demonstrate selected topics. Scheduled to participate in this feature of the program are William F. Mengert, associate professor of obstetrics and gynecology, State University of Iowa College of Medicine, Iowa City; Morris E. Davis, associate professor of obstetrics and gynecology, University of Chicago, The School of Medicine, Chicago, and Carl P. Huber, associate professor of obstetrics, Indiana University School of Medicine, Bloomington–Indianapolis.

Topics selected include an explanation of the use of forceps, indications and contraindications for their use, including the management of occiput posterior, the management of breach presentation, and a discussion of version and extraction.

The complete schedule of the demonstrations is included in the detailed description of this exhibit in the scientific exhibit section of the program.

EXHIBITS IN MAIN ARENA

All of the facilities of the Milwaukee Auditorium will be devoted to scientific and technical exhibits of a varied character. This means of postgraduate medical education has demonstrated its effectiveness.

The technical exhibits make possible your attendance at the One Hundred Second Anniversary Meeting without payment of a registration fee. If it were not for these exhibitors, it would be necessary to charge a minimum registration fee of from $4 to $5. All of the exhibitors have a genuine message for you. You will be well repaid if you will stop at their booths.

Meeting High Lights

SUNDAY, SEPTEMBER 12 . . .

P. M.
2:30 Secretaries' Conference
5:00 House of Delegates—Banquet Room (Fifth Floor), Hotel Schroeder

MONDAY, SEPTEMBER 13 . . .

A. M.
7:30 Registration—Main Arena, Milwaukee Auditorium
Breakfast Round-Tables—Hotel Schroeder
8:00 Scientific Motion Pictures—Plankinton Hall, Milwaukee Auditorium
9:00 General Session—Plankinton Hall, Milwaukee Auditorium
10:00 Recess to View Exhibits
10:30 General Session—Plankinton Hall, Milwaukee Auditorium

P. M.
12:10 Round-Table Luncheons—Hotel Schroeder
2:00 General Session—Plankinton Hall, Milwaukee Auditorium
3:00 Recess to View Exhibits
3:30 General Session—Plankinton Hall, Milwaukee Auditorium
6:45 House of Delegates—Crystal Ballroom (Fifth Floor), Hotel Schroeder
8:00 Smoker—Crystal Ballroom (Fifth Floor), Hotel Schroeder

TUESDAY, SEPTEMBER 14 . . .

A. M.
8:00 House of Delegates—Banquet Room (Fifth Floor), Hotel Schroeder
Scientific Motion Pictures—Plankinton Hall, Milwaukee Auditorium
9:00 General Session—Plankinton Hall, Milwaukee Auditorium
10:00 Recess to View Exhibits
10:30 General Session—Plankinton Hall, Milwaukee Auditorium

P. M.
12:10 Round-Table Luncheons—Hotel Schroeder
2:00 General Session—Plankinton Hall, Milwaukee Auditorium
3:00 Recess to View Exhibits
3:30 General Session—Plankinton Hall, Milwaukee Auditorium
6:45 Annual Dinner—Crystal Ballroom, Hotel Schroeder

WEDNESDAY, SEPTEMBER 15 . . .

A. M.
8:00 Scientific Motion Pictures—Plankinton Hall, Milwaukee Auditorium
9:00 Section on Hospital Relations—Engelmann Hall, Milwaukee Auditorium
Section on Internal Medicine and Cardiology—Plankinton Hall, Milwaukee Auditorium
Section on Obstetrics and Gynecology—South Juneau Hall, Milwaukee Auditorium
Section on Ophthalmology—North Juneau Hall, Milwaukee Auditorium
Section on Orthopedics—Walker Hall, Milwaukee Auditorium
Section on Pediatrics—North Kilbourn Hall, Milwaukee Auditorium
Section on Radiology—Committee Room A, Milwaukee Auditorium
Section on Surgery—South Kilbourn Hall, Milwaukee Auditorium
Section on Urology—Committee Room D, Milwaukee Auditorium

P. M.
12:00 Luncheon, Section on Hospital Relations—Hotel Schroeder
12:10 Round-Table Luncheons—Hotel Schroeder
2:00 General Session—Plankinton Hall, Milwaukee Auditorium
Section on Otolaryngology—North Juneau Hall, Milwaukee Auditorium

OUR GUEST SPEAKERS

Dr. Frank C. Mann
Professor of Pathology and Experimental Physiology and Surgery, University of Minnesota Graduate School, Rochester

Dr. Cecil J. Watson
Professor of Internal Medicine, University of Minnesota Medical School, Minneapolis

Dr. Marion A. Blankenhorn
Professor of Medicine, University of Cincinnati College of Medicine, Cincinnati

Dr. Warren H. Cole
Professor of Surgery, University of Illinois College of Medicine, Chicago

SUNDAY EVENING, SEPTEMBER 12 . . .

5:00 House of Delegates
Banquet Room (Fifth Floor), Hotel Schroeder

MONDAY MORNING, SEPTEMBER 13 . . .

7:30 REGISTRATION
Milwaukee Auditorium

BREAKFAST ROUND TABLES 7:30—8:45 A. M.

Hotel Schroeder

1. Bedside Medicine and Newer Drugs
   Ovid O. Meyer, associate professor of medicine, University of Wisconsin Medical School, Madison
   Parlor A, Fourth Floor
2. Prevention and Treatment of Wound Infections
   Joseph M. King, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee
   Parlor B, Fourth Floor
3. Improvisations to Cope with Medical and Surgical Emergencies in the Home
   Justin D. Leahy, Park Falls
   Parlor C, Fourth Floor
4. Precautions in Absentee Diagnosis, Treatment and Prescribing by Telephone
   Joseph Lettenberger, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee
   Parlor D, Fourth Floor
5. Medication for Common Skin Diseases
   Maurice J. Reuter, Milwaukee
   Parlor E, Fourth Floor
6. Obstetrical Anesthesia
   Arthur A. Cantwell, Shawano
   Parlor F, Fourth Floor

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Subject to be Announced

Symposium on the Liver

9:00 Some Problems in the Physiology of the Liver
Frank C. Mann, professor of pathology and experimental physiology and surgery, University of Minnesota Graduate School, Rochester, Minnesota

9:20 Studies of Liver Disease with Correlation of Clinical Features and Liver Function Tests
Cecil J. Watson, professor of internal medicine, University of Minnesota Medical School, Minneapolis, Minnesota

9:40 Differential Diagnosis of Jaundice
Marion A. Blankenhorn, professor of medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio

10:00 Recess to View Exhibits

> This time is set aside to give you an opportunity to visit the technical and scientific exhibits. Please stop in and see them.

10:30 Surgery of the Biliary Tract
Carl W. Eberbach, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee

10:50 Preoperative and Postoperative Complications and Treatment of the Jaundiced Patient
Matthew A. McGarty, La Crosse

11:10 Summary and Discussion of These Papers
Warren H. Cole, professor of surgery, University of Illinois College of Medicine, Chicago, Illinois

11:30 Recess to View Exhibits

MONDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. Liver Function Tests and Their Clinical Value
   Cecil J. Watson, Minneapolis
   Parlor A, Fourth Floor
2. Jaundice
   Marion A. Blankenhorn, Cincinnati, Ohio
   Parlor B, Fourth Floor
3. Surgical Advances from the War
   Warren H. Cole, Chicago
   Parlor C, Fourth Floor
4. New Advances in Pathology
   Paul R. Cannon, Professor of Pathology, University of Chicago, The School of Medicine, Chicago
   Parlor D, Fourth Floor
5. The Relation of Peptic Ulcer to Cancer of the Stomach
   George B. Eusterman, professor of medicine, University of Minnesota Graduate School, Minneapolis
   Parlor E, Fourth Floor
6. Some Problems in the Physiology of the Liver
   Frank C. Mann, Rochester, Minnesota
   Parlor F, Fourth Floor
7. When Is Peptic Ulcer a Medical and When Is It a Surgical Problem?
   Donald C. Balfour, professor of surgery, University of Minnesota Graduate School, Rochester, Minnesota
   Parlor G, Fourth Floor
8. Jaundice and Its Surgical Aspects
   Matthew A. McGarty, La Crosse
   Parlor H, Fourth Floor
9. Breast Surgery
   Frederick A. Stratton, clinical professor of surgery, Marquette University School of Medicine, Milwaukee
   Parlor I, Fourth Floor
10. Colitis
    Joseph Shaiken, Milwaukee
    Room 607

11. Acute Appendicitis: Treatment
    Erwin R. Schmidt, professor of surgery, University of Wisconsin Medical School, Madison
    Room 619
12. Treatment of Eye Conditions Encountered by the General Practitioner
    Ferdinand H. Haessler, Milwaukee
    Room 707
13. Ear Conditions in General Practice
    William E. Grove, clinical professor of otolaryngology, Marquette University School of Medicine, Milwaukee
    Room F, Fifth Floor
14. What Drugs to Use in the Treatment of Diseases of the Heart
    Chester M. Kurtz, Milwaukee, associate professor of clinical medicine, University of Wisconsin Medical School, Madison
    Pine Room, Fifth Floor
15. New Conceptions in the Administration of Immunization for Whooping Cough and Other Contagious Disease Serums and Vaccines
    William D. Stovall, professor of hygiene, University of Wisconsin Medical School, Madison
    Pere Marquette Room, Fifth Floor
16. Radiologic Problem Clinic for the General Practitioner
    S. Archibald Morton, Milwaukee
    Committee Room, Fifth Floor
17. Obstetrics in the Home
    Woodruff Smith, Ladysmith
    Room B, Fifth Floor
18. Pediatric Practice in the Office and Home
    Abraham B. Schwartz, assistant clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee
    Room C, Fifth Floor
19. Chemotherapy in the Urinary Tract Diseases
    Hartwick M. Stang, Eau Claire
    Room D, Fifth Floor
20. Influence of Surgery on Tuberculosis
    Anthony V. Cadden, Muirdale Sanatorium, Wauwatosa
    Room E, Fifth Floor

MONDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

Symposium on Peptic Ulcer

2:00 Etiology, Pathology and Incidence of Peptic Ulcer
Frederick A. Stratton, Milwaukee

2:20 Bleeding Peptic Ulcer
2:20 Medical Treatment
Joseph Shaiken, Milwaukee
2:40 Surgical Treatment
Russell M. Kurten, Racine, president, The State Medical Society of Wisconsin

3:00 Recess to View Exhibits

> Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

3:30 Preparation of Physicians for the Armed Services
Rear Admiral Ross T. McIntire, Surgeon General of the United States Navy, Washington, D. C.

4:00 Observations on Gastric Carcinoma in Its Earliest Stages
George B. Eusterman, Rochester, Minnesota

4:20 Operation of Choice in Peptic Ulcer
Erwin R. Schmidt, professor of surgery, University of Wisconsin Medical School, Madison

4:40 Discussion and Summary of Symposium
Donald C. Balfour, Rochester, Minnesota

Scientific Motion Pictures

MONDAY EVENING . . .

6:45 House of Delegates

Crystal Ballroom (Fifth Floor), Hotel Schroeder

8:00 Smoker

OUR GUEST SPEAKERS

Rear Admiral Ross T. McIntire

Surgeon General of the United States Navy, Washington, D. C.

Dr. George B. Eusterman

Professor of Medicine, University of Minnesota Graduate School, Minneapolis

Dr. Donald C. Balfour

Professor of Surgery, University of Minnesota Graduate School, Rochester

Dr. John Romano

Professor of Psychiatry, University of Cincinnati College of Medicine, Cincinnati

TUESDAY MORNING, SEPTEMBER 14 . . .

8:00 **House of Delegates**
Banquet Room (Fifth Floor), Hotel Schroeder

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:00 Scientific Motion Pictures
Subject to be Announced

9:00 Problems in Plastic Surgery of the Face
C. R. Dix, instructor in maxillo-facial surgery, Marquette University School of med.cine, Milwaukee

9:20 The Place of Sulfonamides in Surgery
Arnold S. Jackson, Madison

9:40 Psychiatric Problems Arising from Military Service
John Romano, professor of psychiatry, University of Cincinnati College of Medicine, Cincinnati, Ohio

10:00 Recess to View Exhibits

> The technical exhibits make it possible to present the annual meeting without a registration fee. Express your appreciation to the exhibitors by visiting their booths.

10:30 Virus Diseases of Man

Edward R. Krumbiegel, assistant clinical professor of public health, Marquette University School of Medicine, Milwaukee

10:50 Reports of Officers

11:10 Address of President

TUESDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. Medical Problems Confronting Asylum Physicians and Superintendents
   Henry H. Christofferson, Colby, chairman, Committee on Mental Hygiene and Institutional Care
   Parlor A, Fourth Floor
2. Psychiatric Examination in General Practice
   Saul K. Pollack, Milwaukee
   Parlor B, Fourth Floor
3. Transfusions and Fluid Balance
   Frederick A. Coller, professor of surgery, University of Michigan Medical School, Ann Arbor, Michigan
   Parlor C, Fourth Floor
4. Treatment of Patients Suffering from Wounds due to Poison Gas
   Raymond F. Wagner, Oshkosh
   Anthony R. Curreri, assistant professor of surgery, University of Wisconsin Medical School, Madison
   Elston L. Belknap, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee
   Parlor D, Fourth Floor
5. Sulfonamides in Surgical Practice
   Arnold S. Jackson, Madison
   Parlor E, Fourth Floor
6. Diagnosis and Treatment of Cancer of the Bowel
   Claude F. Dixon, associate professor of surgery, University of Minnesota Graduate School, Rochester, Minnesota
   Parlor F, Fourth Floor
7. Diseases of Viral Etiology
   Edward R. Krumbiegel, Milwaukee
   Rear of Banquet Room, Fifth Floor
8. Anemias and Leukemias
   Frederick W. Madison, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee
   Parlor H, Fourth Floor
9. Emotional Disorders in Selective Service
   Major John A. Grab, M. C., United States Selective Service, Madison
   Parlor I, Fourth Floor
10. Virus Pneumonia: Diagnosis and Complications
    Alvin G. Koehler, Oshkosh
    Room 607
11. Soldier's Heart
    Major Paul L. Eisele, M. C., United States Selective Service, Milwaukee
    Room 619
12. Urinary Tract Diseases
    Robert S. Irwin, Milwaukee
    Room 707
13. Toxic Reactions of Dinitrotoluene
    Howard L. Reed, medical director, Badger Ordnance Works, Baraboo
    Pine Room
14. Poliomyelitis: Immediate and Remote Results
    Eben J. Carey, dean and professor of anatomy, Marquette University School of Medicine, Milwaukee
    Committee Room, Fifth Floor
15. Irradiation Treatment of Carcinoma (External)
    Harry R. Foerster, assistant professor of dermatology, University of Wisconsin Medical School, Madison, and assistant clinical professor of dermatology, Marquette University School of Medicine, Milwaukee
    Pere Marquette Room, Fifth Floor
16. Psychosomatic Medicine
    John Romano, professor of psychiatry, University of Cincinnati College of Medicine, Cincinnati, Ohio
    Room B, Fifth Floor
17. Medical Problems Created by Employment of Women in Industry
    Paul A. Brehm, director, Industrial Hygiene Unit, State Board of Health, Madison
    Herbert G. Brehm, Racine
    Mr. G. F. Nuernberger, supervisor, Health and Safety Division, Industrial Relations Department, Allis Chalmers, Milwaukee
    Room C, Fifth Floor

18. Fracture Problems
    Robert P. Montgomery, Milwaukee
    Room D, Fifth Floor

19. Local Anesthesia in Sprains and Strains
    Chester C. Schneider, Milwaukee
    Room E, Fifth Floor

20. Induction of Labor
    George W. Walter, Racine
    Arthur A. Cantwell, Shawano
    Room F, Fifth Floor

21. Past-Presidents' Luncheon
    Gunnar Gundersen, La Crosse
    Parlor G, Fourth Floor

TUESDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

2:00 Uses of Blood Substitutes in Hemorrhage, Shock and Protein Deficiencies
Frederick A. Coller, professor of surgery, University of Michigan Medical School, Ann Arbor, Michigan

2:20 Immediate and Remote Complications of Sulfonamide Therapy
John C. Grill, associate professor of pathology and bacteriology, Marquette University School of Medicine, Milwaukee

2:40 Medical Aspects of Chemical Warfare
John S. Coulter, associate professor of physical therapy, Northwestern University Medical School, Chicago

3:00 Recess to View Exhibits

> Take this time to visit the technical and scientific exhibits. The exhibitors will appreciate seeing you.

3:30 Present Status of Hemorrhagic Diseases
Frederick W. Madison, Milwaukee

Dr. John S. Coulter
Associate Professor of Physical Therapy, Northwestern University Medical School, Chicago. Regional Medical Officer, Sixth Civilian Defense Region

3:50 Cancer of the Bowel: Surgical Treatment
Claude F. Dixon, associate professor of surgery, University of Minnesota Graduate School, Rochester, Minnesota

4:10 A Contrast of Selective Service and United States Army Physical Examinations
Major John A. Grab, M. C., United States Selective Service, Madison

4:30 Scientific Motion Pictures
Subject to be Announced

6:45 ANNUAL DINNER
Hotel Schroeder, Crystal Ballroom

WEDNESDAY MORNING, SEPTEMBER 15 . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

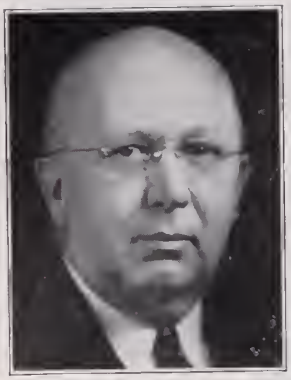
8:00 Scientific Motion Pictures
Subjects to be Announced

SECTION ON HOSPITAL RELATIONS . . .

Engelmann Hall, Milwaukee Auditorium, Second Floor

Chairman: John E. Habbe, assistant clinical professor of roentgenology, Marquette University School of Medicine, Milwaukee

9:00 Professional Accounting
Harold M. Coon, professor of hospital administration, University of Wisconsin Medical School, Madison



Dr. William A. O'Brien

Professor of Preventive Medicine and Public Health, University of Minnesota Medical School, Minneapolis

Mr. J. W. Holloway, Jr.

Director, Bureau of Legal Medicine and Legislation, American Medical Association, Chicago

Dr. William A. Coventry

Duluth, Minnesota

Father Alphonse M. Schwitalla, S. J., Ph. D.

Dean, St. Louis University School of Medicine, St. Louis

9:20 Problems Concerning Graduate Education and Employment of Nurses, Interns and Residents
William A. O'Brien, professor of preventive medicine and public health, University of Minnesota Medical School, Minneapolis

9:40 Hospitals in the Selection of Medical Staffs
Mr. J. W. Holloway, Jr., director, Bureau of Legal Medicine and Legislation, American Medical Association, Chicago

10:00 Recess to View Exhibits

Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

10:30 Interhospital Relations
William A. Coventry, Duluth, Minnesota

10:50 The Hospital Library
Gorton Ritchie, Racine

11:10 Practical Experience with the Trained Attendants
Miss Katheryn Sheppard, director, Household Nursing Corporation, Boston

11:30 Recess to View Exhibits

NOON LUNCHEON

Hotel Schroeder, Banquet Room, Fifth Floor

12:00 Administrative and Professional Problems of Medical Practice in the Hospital
Father Alphonse M. Schwitalla, S. J., Ph. D., dean, St. Louis University School of Medicine, St. Louis, Missouri

TELEPHONE SERVICE AT AUDITORIUM

Your telephone number at the Milwaukee Auditorium will be Broadway 8030. When you leave to attend sessions of the One Hundred Second Anniversary Meeting, leave word at your home and office that you can be reached at that number.

SECTION ON INTERNAL MEDICINE AND CARDIOLOGY . . .

Dr. Chauncey C. Maher
Associate Professor of Medicine, Northwestern University Medical School, Chicago

Dr. Paul S. Rhoads
Associate Professor of Medicine, Northwestern University Medical School, Chicago

Plankinton Hall, Milwaukee Auditorium, Second Floor

Chairman: Alvin G. Koehler, Oshkosh

8:40 Neurologic Conditions of Interest to the General Practitioner
John L. Garvey, clinical professor of neurology, Marquette University School of Medicine, Milwaukee

9:00 Chronic Diseases of the Lung Mistaken for Tuberculosis
Anthony V. Cadden, Muirdale Sanatorium, Wauwatosa

9:20 Recognition of Early Myocardial Failure
Chauncey C. Maher, associate professor of medicine, Northwestern University Medical School, Chicago, Illinois

10:00 Recess to View Exhibits

> Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

10:30 Rheumatic Fever: Diagnosis and Treatment
Paul S. Rhoads, associate professor of medicine, Northwestern University Medical School, Chicago

Major C. S. Higley
Chief of Medical Service, Truax Field, Madison

10:50 Treatment of the Various Pneumonias
Major C. S. Higley, Truax Field, Madison

11:10 Recent Advances in Diabetes Mellitus
Elwood W. Mason, clinical instructor in medicine, Marquette University School of Medicine, Milwaukee

11:30 Recess to View Exhibits

SECTION ON OBSTETRICS AND GYNECOLOGY . . .

South Juneau Hall, Milwaukee Auditorium, First Floor

Chairman: Robert L. Cowles, Green Bay

9:00 Continuous Caudal Anesthesia
Hugh A. Cunningham, assistant clinical professor of anesthesia, Marquette University School of Medicine, Milwaukee

9:20 Discussant:
John W. Harris, professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison

9:30 Diagnosis of Carcinoma of the Uterus
Ralph E. Campbell, associate professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison

9:50 Discussant:

Albert H. Lahmann, associate clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee

10:00 Recess to View Exhibits

Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

10:30 Diabetes in Pregnancy

George S. Kilkenny, instructor in obstetrics and gynecology, Marquette University School of Medicine, Milwaukee

10:50 Discussant:

Elmer L. Sevringhaus, professor of medicine, University of Wisconsin Medical School, Madison

Dr. Ralph A. Reis

Assistant Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago

11:00 Sterility

Ralph A. Reis, assistant professor of obstetrics and gynecology, Northwestern University Medical School, Chicago

11:20 Discussant:

Carl S. Harper, assistant clinical professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison

11:30 Recess to View Exhibits

SECTION ON OPHTHALMOLOGY . . .

Dr. Sanford R. Gifford

Professor of Ophthalmology, Northwestern University Medical School, Chicago

North Juneau Hall, Milwaukee Auditorium, First Floor

Chairman: William E. Grove, clinical professor of otolaryngology, Marquette University School of Medicine, Milwaukee

9:00 The Eye in General Diagnosis

Sanford R. Gifford, professor of ophthalmology, Northwestern University Medical School, Chicago

9:20 Vision in Anisometropia

Lyman A. Copps, Marshfield Clinic, Marshfield

9:40 Discussant:

Jasper M. Molsberry, Milwaukee

10:00 Recess to View Exhibits

Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

10:30 Complications in Cataract Surgery

Raymond C. Warner, Milwaukee

10:50 Discussion

Frederick A. Davis, professor of ophthalmology, University of Wisconsin Medical School, Madison

11:00 Evaluation of Blood Studies in Postoperative Bleeding after Cataract Surgery

Eugene E. Neff, associate professor of ophthalmology, University of Wisconsin Medical School, Madison

11:20 Discussion

F. Herbert Haessler, Milwaukee

11:30 Recess to View Exhibits

SECTION ON ORTHOPEDICS . . .

Walker Hall, Milwaukee Auditorium, First Floor

Chairman: Robert E. Burns, professor of orthopedic surgery, University of Wisconsin Medical School, Madison

9:00 Posture in School Children
David J. Ansfield, Milwaukee

9:30 The Value of Early Recognition of Congenital Dislocation of the Hip
Vernon C. Turner, Milwaukee

10:00 Recess to View Exhibits

> Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

10:30 Sequelae of Fractured Hips and Their Treatment
Chester C. Schneider, Milwaukee

11:00 Low Back Injuries and Compensation Cases
W. E. Wolcott, Green Bay

11:30 Recess to View Exhibits

SECTION ON PEDIATRICS . . .

Dr. Hart E. Van Riper
Assistant Director for Maternal and Child Health, Division of Health Services, Washington, D. C.

Dr. Paul H. Holinger
Assistant Professor of Laryngology, University of Illinois College of Medicine, Chicago

North Kilbourn Hall, Milwaukee Auditorium, First Floor

Chairman: Henry A. Sincock, Superior

9:00 Better Health for Children: Physicians and the Social Security Program
Hart E. Van Riper, assistant director for maternal and child health, Division of Health Services, Washington, D. C.

9:20 Reducing the Hazards of the First Week of Life
John W. Prentice, Ashland
Discussant:
Samuel E. Kohn, Milwaukee

9:40 The Infant Larynx
Paul H. Holinger, assistant professor of laryngology, University of Illinois College of Medicine, Chicago

10:00 Recess to View Exhibits

> Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

Dr. Edgar J. Huenekens
Clinical Professor of Pediatrics, University of Minnesota Graduate School and University of Minnesota Medical School, Minneapolis

10:30 Immunization in Pediatric Practice
Edgar J. Huenekens, clinical professor of pediatrics, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis; member of the Immunization Committee of the American Academy of Pediatrics

10:50 Discussant:
S. F. Morgan, assistant clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee

11:00 Malocclusion and Malformations of the Jaws and Face in Children Necessitating Early Orthodontic and Surgical Care
Matthew N. Federspiel, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee

11:20 Discussion
Dr. Russell A. Hering, Milwaukee

11:30 Recess to View Exhibits

SECTION ON RADIOLOGY . . .

Committee Room A, Milwaukee Auditorium, Second Floor

Chairman: Lester W. Paul, Madison

9:00 Business Meeting of Section

9:30 Experiences with Priodax, a New Dye for Gallbladder Visualization
Hans W. Hefke, Milwaukee

9:50 Discussion

10:00 Recess to View Exhibits

> Don't fail to see the fine display of technical and scientific exhibits in the main arena.

10:30 Round-Table Discussion with Case Reports
William T. Clark, Janesville
Theodore Sokow, Kenosha
S. Archibald Morton, Milwaukee
Ernst A. Pohle, Madison
Ivan G. Ellis, Madison
Lester W. Paul, Madison

11:30 Recess to View Exhibits

SECTION ON SURGERY . . .

South Kilbourn Hall, Milwaukee Auditorium, First Floor

Chairman: Dexter H. Witte, Milwaukee

9:00 Infections and Surgery of the Hand
Thomas J. Snodgrass, Janesville

9:20 Discussion
Thomas S. O'Malley, Milwaukee, plant surgeon, A. O. Smith Corporation

9:30 Improved Surgical Treatments of Hernias
Leo M. Zimmerman, assistant professor of surgery, Northwestern University Medical School, Chicago

9:50 Discussion
Irwin Schulz, Milwaukee

10:00 Recess to View Exhibits

> Take this time to visit the technical and scientific exhibitors; they will appreciate seeing you.

10:30 Skin Grafting of Burns
Frank McDowell, assistant professor of clinical surgery, Washington University School of Medicine, St. Louis

10:50 Discussion
Volney B. Hyslop, professor of oral and plastic surgery, University of Wisconsin Medical School, Madison

11:00 Intravenous Use of Amino Acids
Anthony R. Curreri, assistant professor of surgery, University of Wisconsin Medical School, Madison

11:20 Discussion

SECTION ON UROLOGY . . .

Dr. John L. Emmett
Rochester, Minnesota

Committee Room D, Milwaukee Auditorium

Chairman: Walter M. Kearns, Milwaukee

9:00 Newer Methods in the Treatment of Urological Conditions
Hartwick M. Stang, Eau Claire

9:20 Management of Ureteral Stone
Alexander D. Spooner, Milwaukee

9:40 Upper Urinary Tract Problems in Infants and Children
N. Warren Bourne, Milwaukee

10:00 Recess to View Exhibits

> Don't fail to see the fine display of technical and scientific exhibits in the main arena.

10:30 Discussion of Urinary Tract Injuries
Robert S. Irwin, associate professor of urology, Marquette University School of Medicine, Milwaukee

10:50 Historic Background of Litholapaxy
John L. Emmett, Rochester, Minnesota

11:10 Treatment of Resistant Infections in the Urinary Tract
Charles D. Creevy, assistant dean and professor of surgery and urology, University of Minnesota Medical School, Minneapolis

11:30 Discussion

WEDNESDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. The Problem of Tuberculosis
   Oscar Lotz, W. A. T. A., Milwaukee
   Parlor A, Fourth Floor
2. Treatment of Heart Failure
   Chauncey C. Maher, associate professor of medicine, Northwestern University Medical School, Chicago
   Parlor B, Fourth Floor
3. Prophylaxis of Rheumatic Fever
   Paul S. Rhoads, assistant professor of medicine, Northwestern University Medical School, Chicago
   Parlor C, Fourth Floor
4. Skin Manifestations of Systemic Diseases
   John W. Smith, Milwaukee
   Parlor D, Fourth Floor
5. Lung Diseases Simulating Pneumonia
   Major C. S. Higley, Chief of Medical Service, Truax Field, Madison
   Parlor E, Fourth Floor
6. Paralytic Squint
   Sanford R. Gifford, professor of ophthalmology, Northwestern University Medical School, Chicago
   Parlor F, Fourth Floor

7. Acute Upper Respiratory Infections and Their Control
   Dean M. Lierle, professor of otolaryngology, State University of Iowa College of Medicine, Iowa City, Iowa
   Parlor G, Fourth Floor
8. Hernias and the Wisconsin Compensation Act
   Gunnar Gundersen, La Crosse, chairman, Committee on Industrial Health
   Mr. Harry A. Nelson, director, Workmen's Compensation Division, Wisconsin Industrial Commission, Madison
   Parlor H, Fourth Floor
9. Treatment of Urinary Stones
   John L. Emmett, Rochester, Minnesota
   Parlor I, Fourth Floor
10. Urinary Diagnosis
    Charles D. Creevy, Minneapolis
    Room 607
11. Environment and Child Health in the City
    Hart E. Van Riper, assistant director for Maternal and Child Health, Division of Health Services, Washington, D. C.
    Room 719
12. Laryngeal Disease in Infancy
    Paul H. Holinger, assistant professor of laryngology, University of Illinois College of Medicine, Chicago
    Room 707
13. The Prevention of Disease in Children
    Edgar J. Huenekens, clinical professor of pediatrics, University of Minnesota Medical School, Minneapolis; member of the Immunization Committee for the American Academy of Pediatrics
    Pine Room, Fifth Floor
14. Treatment of Sterility
    Ralph A. Reis, Chicago
    Committee Room, Fifth Floor
15. Diagnosis and Localization of Brain Tumors by Roentgen Methods
    Lester W. Paul, associate professor of radiology, University of Wisconsin Medical School, Madison, and Theodore C. Erickson, associate professor of surgery, University of Wisconsin Medical School, Madison
    Pere Marquette Room, Fifth Floor
16. Rheumatic Heart Disease
    Vincent W. Koch, Janesville
    Room B, Fifth Floor
17. The Use of Intravenous Amino Acids in General Hospital Practice
    Anthony R. Curreri, assistant professor of surgery, University of Wisconsin Medical School, Madison
    Room C, Fifth Floor
18. Tropical Diseases
    Marcos Fernan-Nunez, professor of pathology and bacteriology and associate professor of public health, Marquette University School of Medicine, Milwaukee
    Room D, Fifth Floor
19. Fractures That May Be Missed
    John B. MacLaren, Appleton
    Room E, Fifth Floor
20. Abdominal Diagnosis in General Practice
    Lawrence D. Quigley, Green Bay
    Room F, Fifth Floor

WEDNESDAY AFTERNOON . . .

GENERAL SESSION . . .

Captain William E. Eaton, M. C., U. S. N.

Medical Officer in Command, U. S. Naval Hospital, Great Lakes, Illinois

Plankinton Hall, Milwaukee Auditorium

2:00 Tropical Medicine Here and in the Tropics
Marcos Fernan-Nunez, Milwaukee

2:30 Ulcer Problems in the Armed Forces
Captain William E. Eaton, M. C., U. S. N., Medical Officer in Command, U. S. Naval Hospital, Great Lakes, Illinois

3:00 Medical Education and the Armed Forces
Eben J. Carey, dean and professor of anatomy, Marquette University School of Medicine, Milwaukee

3:30 The Fate of the Practice of Medicine after the War
Alphonse M. Schwitalla, S. J., Ph. D., dean, St. Louis University School of Medicine, St. Louis, Missouri

SECTION ON OTOLARYNGOLOGY . . .

Dr. Dean M. Lierle
Professor of Otolaryngology, State University of Iowa College of Medicine, Iowa City

North Juneau Hall, Milwaukee Auditorium, First Floor

Chairman: William E. Grove, Milwaukee

2:00 Conservation of Hearing
Dean M. Lierle, professor of otolaryngology, State University of Iowa College of Medicine, Iowa City, Iowa

2:20 Vertigo and Its Treatment
Thomas L. Tolan, Milwaukee

2:40 Discussion
Thomas F. McCormick, assistant clinical professor of otolaryngology, Marquette University School of Medicine, Milwaukee

2:45 Fundamental Principles in the Diagnosis and Treatment of Respiratory Allergy
John A. Hurlbut, Madison

3:05 Discussion
William J. Frawley, Appleton

3:10 The Management of the Chronic Draining Middle Ear
Fred W. Kundert, Monroe

3:30 Discussion
William G. Meier, Sheboygan

Members—1943 House of Delegates

Society	*Delegate*	*Alternate Delegate*
Ashland–Bayfield–Iron	R. O. Grigsby, Ashland	J. W. Prentice, Ashland
Barron–Washburn–Sawyer–Burnett	D. L. Dawson, Rice Lake	S. O. Lund, Cumberland
Brown–Kewaunee–Door	P. R. Minahan, Green Bay	E. S. McNevins, Green Bay
	O. A. Stiennon, Green Bay	W. E. Leaper, Green Bay
Calumet	A. C. Engel, New Holstein	P. J. Mollersheim, Forest Junction
Chippewa	A. J. Somers, Chippewa Falls	Frank Sazama, Chippewa Falls
Clark	H. H. Christofferson, Colby	Not Reported
Columbia–Marquette–Adams	L. V. McNamara, Montello	E. F. Tierney, Portage
Crawford	E. M. Dessloch, Prairie du Chien	G. R. Hammes, Seneca
Dane	C. O. Vingom, Madison	J. E. Gonce, Jr., Madison
	A. R. Tormey, Madison	W. H. Marsden, Madison
	H. E. Marsh, Madison	L. R. Cole, Madison
	Louis Fauerbach, Madison	N. A. Hill, Madison
Dodge	W. E. Bargholtz, Reeseville	F. G. Bachhuber, Mayville
Douglas	J. W. McGill, Superior	H. J. Orchard, Superior
Eau Claire–Dunn–Pepin	W. R. Manz, Eau Claire	B. F. Johnson, Mondovi
Fond du Lac	D. J. Twohig, Sr., Fond du Lac	D. N. Walters, Fond du Lac
Forest	G. E. Carroll, Laona	H. C. Marsh, Crandon
Grant	J. H. Fowler, Lancaster	E. H. Spiegelberg, Boscobel
Green	J. A. Schindler, Monroe	L. E. Creasy, Monroe
Green Lake–Waushara	J. A. Kelly, Green Lake	H. C. Koch, Berlin
Iowa	S. B. Marshall, Hollandale	H. M. Walker, Dodgeville
Jefferson	G. E. Eck, Lake Mills	O. F. Dierker, Watertown
Juneau	C. A. Vogel, Elroy	A. R. Kaufman, Mauston
Kenosha	W. C. Stewart, Kenosha	L. T. Kent, Kenosha
La Crosse	F. A. Douglas, La Crosse	Jens Rosholt, La Crosse
Lafayette	Not Reported	Not Reported
Langlade	C. E. Zellmer, Antigo	W. P. Curran, Antigo
Lincoln	R. G. Baker, Tomahawk	K. A. Morris, Merrill
Manitowoc	E. C. Cary, Reedsville	T. H. Rees, Manitowoc
Marathon	J. F. Smith, Wausau	E. E. Flemming, Wausau
Marinette–Florence	A. T. Nadeau, Marinette	H. W. Haasl, Peshtigo
Milwaukee	C. R. Marquardt, Milwaukee	M. C. Borman, Milwaukee
	Charles Fidler, Milwaukee	B. P. Churchill, Milwaukee
	Irwin Schulz, Milwaukee	M. W. Sherwood, Milwaukee
	W. M. Kearns, Milwaukee	J. E. Mulsow, Milwaukee
	C. M. Echols, Milwaukee	C. F. Conroy, Milwaukee
	W. A. Ryan, Milwaukee	T. F. McCormick, Milwaukee
	Norbert Enzer, Milwaukee	C. C. Schneider, Milwaukee

Society	Delegate	Alternate Delegate
	R. F. Purtell, Milwaukee	Benjamin Lieberman, Milwaukee
	R. E. Galasinski, Milwaukee	W. L. MacKedon, Milwaukee
	L. J. Van Hecke, Milwaukee	S. M. Morton, Milwaukee
	E. J. Carey, Milwaukee	M. J. Fox, Milwaukee
	S. M. Markson, Milwaukee	Edgar Habeck, Milwaukee
	J. C. Griffith, Milwaukee	Mark Bach, Milwaukee
	J. J. Pink, Milwaukee	J. M. Fons, Milwaukee
	L. W. Hipke, Milwaukee	T. J. Aylward, Milwaukee
	H. J. Gramling, Milwaukee	Aaron Yaffee, Milwaukee
	G. S. Flaherty, Milwaukee	O. A. Sander, Milwaukee
Monroe	C. S. Phalen, Sparta	L. G. Scheurich, Tomah
Oconto	A. F. Slaney, Oconto	C. R. Kwapy, Oconto
Oneida–Vilas	W. S. Bump, Rhinelander	I. E. Schiek, Rhinelander
Outagamie	G. W. Carlson, Appleton	D. W. Curtin, Little Chute
Pierce–St. Croix	C. E. McJilton, River Falls	O. H. Epley, New Richmond
Polk	L. O. Simenstad, Osceola	K. F. Johnson, Frederic
Portage	A. G. Dunn, Stevens Point	E. Wisiol, Stevens Point
Price–Taylor	J. D. Leahy, Park Falls	L. E. Nystrum, Medford
Racine	T. C. Hemmingsen, Racine	E. J. Schneller, Racine
Richland	George Parke, Sr., Viola	G. H. Benson, Richland Center
Rock	H. E. Kasten, Beloit	W. A. Munn, Janesville
Rusk	L. M. Lundmark, Ladysmith	Woodruff Smith, Ladysmith
Sauk	A. C. Edwards, Baraboo	F. R. Winslow, Baraboo
Shawano	A. A. Cantwell, Shawano	O. F. Partridge, Mattoon
Sheboygan	C. J. Weber, Sheboygan	A. C. Radloff, Plymouth
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Whitehall	Robert Krohn, Black River Falls
Vernon	W. M. Trowbridge, Viroqua	J. J. Rouse, Hillsboro
Walworth	E. D. Sorenson, Elkhorn	D. H. Jeffers, Lake Geneva
Washington–Ozaukee	Arnold Barr, Port Washington	J. G. Hoffmann, Hartford
Waukesha	R. E. Davies, Waukesha	H. T. Barnes, Delafield
Waupaca	A. M. Christofferson, Waupaca	J. H. Murphy, Clintonville
Winnebago	A. G. Koehler, Oshkosh	J. P. Canavan, Neenah
Wood	K. H. Doege, Marshfield	F. X. Pomainville, Wisconsin Rapids
Section on Cardiology	Albert Bryan, Madison	Francis Murphy, Milwaukee
Section on Ophthalmology and Otolaryngology	J. K. Trumbo, Wausau	A. H. Pember, Janesville
Section on Orthopedics	R. P. Montgomery, Milwaukee	L. D. Smith, Milwaukee
Section on Radiology	J. E. Habbe, Milwaukee	L. V. Littig, Madison

SCIENTIFIC EXHIBITS

Dr. Carl D. Neidhold of Appleton is the member of the Council on Scientific Work who was chosen this year to direct the scientific exhibits for the Annual Meeting

Applied Anatomy

Walter Zeit, Ph. D., assistant professor of anatomy, Marquette University School of Medicine, Milwaukee; and A. R. Curreri, assistant professor of surgery, University of Wisconsin Medical School; and Otto A. Mortensen, associate professor of anatomy, University of Wisconsin Medical School, Madison

The exhibit will present an anatomic dissection of the anterior abdominal wall with special reference to incisions for the approach of gall bladder, stomach, duodenum, appendix and hernial repair. The exhibit will stress what an ideal incision should offer the surgeon and patient alike. The ideal incision for the surgeon is one that will give excellent exposure of the operative field involved and which can be approached readily without too much bleeding. The patient, on the other hand, desires an abdominal wound which on healing will approach normal and which is not subject to hernias. The exhibitors will demonstrate why some incisions are ideal for the surgeon and not for the patient, and why others are ideal for the patient but not the

surgeon. An attempt will be made to demonstrate incisions that will give the surgeon optimum exposure and at the same time give the best possible wound to the patient.

Tropical Diseases

M. Fernan-Nunez, professor of pathology and bacteriology and associate professor of public health, Marquette University School of Medicine, Milwaukee

This is an exhibit emphasizing the dissemination of exotic diseases throughout the United States by increased travel and modern means of rapid transportation, especially by service men returning from war in tropical regions. The exhibit displays specimens of various parasites, eggs of helminths, insect vectors, specimens of pathologic anatomy of parasitic diseases and microphotographic transparencies of microscopic preparations. Motion pictures of parasites and patients affected with various tropical diseases will be shown.

Treatment of Fractures of Forearm, Hip, Os Calcis and Ankle Joint

J. O. Dieterle, Milwaukee

I—Single or double forearm fractures in the middle one third are often hard to reduce by closed methods. In this exhibit the technic of the open reduction method of Hey-Groves, utilizing beef bone intramedullary pegs, will be illustrated. The operation is not difficult and affords a method of getting accurate reduction of the fragments. As a rule, it is not used in children, although in certain instances it may be necessary.

II—Fracture dislocations of the ankle joint involving the lower tibial articulation should be accurately reduced and maintained by combined internal and external fixation. In certain cases the dislocated foot cannot be held reduced by simple application of a plaster cast. The exhibit will show the author's method of maintaining reduction by the use of transfixing wires.

III—In this exhibit the method of maintaining reduction in intracapsular fractures of the hip by the use of Telson screws will be illustrated. The screws are introduced subcutaneously and without the use of any special apparatus. The procedure here shown is not anything new but is presented as one of the less complicated methods of treatment of hip fractures.

IV—In the exhibit the apparatus used for skeletal traction in fractures of the os calcis will be presented. Stress is made on the necessity of restoring the contour of the os calcis as much as possible. Many of the important points in the treatment will be emphasized.

Prevention of Deformity

Wisconsin Rheumatism Association

The first line of defense in the care of rheumatic patients is to diagnose correctly the type of disturbance. The second line of defense is the prevention of deformity. This is of social and economic as well as medical significance.

In this exhibit the prevention of the various types of deformities will be presented. The early recognition of impending deformity will be stressed as well as the technic of deformity prevention which can be employed by a physician interested in rheumatism.

Pyloric Stenosis

A. A. Schaefer, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee; and H. W. Hefke, Milwaukee

The exhibit consists of posters indicating the diagnosis of pyloric stenosis and anatomic studies of the pylorus in both normal infants and those having hypertrophic pyloric stenosis. The photographs are of the normal pyloric muscle and microphotographs of normal muscle and hypertrophic pyloric stenosis. There are roentgenograms of the pylorus and stomach of healthy infants and of infants with hypertrophic pyloric stenosis. In the latter, there is always a ronentgenologically demonstrable filling defect in the pyloric region which corresponds to the tumor. The pyloric opening time is of some importance while size, shape, and emptying time of the stomach are of practically no importance for the roentgen diagnosis. The roentgen examination is very reliable if certain technical factors are strictly adhered to. In 50 cases with surgically proved pyloric stenosis, the roentgen examination had demonstrated the presence of it. In no cases with a roentgenologically normal stomach was a tumor found at operation. Roentgen examination in questionable cases of hypertrophic pyloric stenosis is a very reliable and not often enough used diagnostic method.

Cancer and the Women's Field Army

Wisconsin Division, Women's Field Army

The four exhibits to be shown are of a newer, more challenging calibre than those used in previous years. They are in keeping with the educational program of the Women's Field Army and the 1943 slogan, "With your Aid We shall Be Victorious in the War on Cancer".

The exhibits are titled:

"War on Cancer Must Go On," "Safe Weapons against Cancer," "Delay Kills," and "Cancer is always an Emergency."

Physicians may recall seeing the exhibits pictured in the April 1943 issue of the Field Army Bulletin. If members of the Society are not receiving their copy, please drop a card to the editor, Mrs. G. E. Stoddart, Beaver Dam, Wisconsin. Every Wisconsin Society member should be in receipt of the Bulletin. It is a state specific project and has three objectives: (1) to keep the members in touch with Women's Field Army, (2) to serve as a medium of exchange of ideas and working plans for the officers, and (3) to bring factual cancer information to the lay members of the Wisconsin Division. In addition to the posters, the latex models will be shown.

Medical Literature For Loan

Gladys Ramsey, Librarian, Medical Library Service, Madison

The library exhibit will feature late editions of books and journal articles on industrial medicine and hygiene, tropical diseases, military surgery, chemical warfare, war neuroses, and rehabilitation.

Sample reference requests received during the previous year will be posted. Envelopes of letters received from Wisconsin physicians stationed at various army posts will be displayed.

Available for free distribution will be the usual lists of periodicals and new books added to the Medical Library Service at the University of Wisconsin during 1942 and 1943.

Automobile Drivers Clinic

Wisconsin Motor Vehicle Department, Madison

The "drivers' clinic," an exhibit of the safety division of the state motor vehicle department, is composed of a dozen varied tests to determine driving capabilities.

A large share of the tests are devoted to examination of the eyes for color blindness, depth perception, distance judgment, field of vision, visual acuity and reaction to headlight glare. A reactometer machine is used to determine braking reaction time and ability to coordinate eye and hand movements in steering. Knowledge of fundamental Wisconsin traffic laws is tested on a device which permits one to answer "yes or "no" to a series of questions, with a red light flashing on for an incorrect answer, an orange light for two incorrect answers and a gong ringing if three questions are wrong. All correct answers are given the green light.

This clinic has been in operation for six years, visiting high schools, teachers' colleges, conventions, fairs, and industrial firms. While the CCC camps were in operation, the clinic was used to test every CCC driver in the state of Wisconsin. During the past school year, the clinic was set up for two-day and three-day stands in numerous high schools offering driver education courses.

Accurate Reporting of Births

State of Wisconsin Board of Health, Madison

The physician's responsibility in filling out birth certificates promptly, accurately, and completely is the theme of the exhibit being prepared by the Wisconsin State Board of Health for the Annual Meeting of the State Medical Society.

Each month the Bureau of Vital Statistics finds it necessary to question approximately 500 physicians for items omitted from original birth and death records. Doctors available for civilian practice are decreasing in number daily. Their time is becoming increasingly limited. To conserve that time, concrete suggestions will be made. A large birth certificate will be featured, with lighting effects and other attention getting devices drawing attention to the items on the certificate that are most frequently omitted by doctors in attendance at births.

One of the requirements for gaining access to war industries and for obtaining certain positions in the armed services is proof of United States ciitzenship. The birth certificate is that proof, and the physician sets in motion the machinery for providing it. These and other uses of the birth certificate are brought out in the exhibit.

Spread and Control of Tularemia

American Medical Association, Chicago

Over a ten year period, 300 cases of tularemia were reported in Wisconsin. Rabbits are the most prolific source of infection of the disease in the United States, being responsible for over 90 per cent of human infections. Other animals and birds, which are potential sources of danger, include the coyote, woodchuck, opossum, ground squirrel, sage hen, quail, ruffed grouse, sharp-tailed grouse, tree squirrel, skunk, muskrat, wild rat (in California), and field mouse (in California). The wood tick is responsible for the disease in the Northwest and the dog tick in the South. The deer fly transmits the disease also, especially in Utah and the surrounding states.

The best protection against tularemia is obtained by avoiding contact with infected animals. Hunters should avoid rabbits that are sluggish or refuse to run. Persons dressing wild rabbits should wear rubber gloves, if possible. Scratches and abrasions should be disinfected immediately. Rabbit meat for human consumption should be cooked thoroughly to destroy any possible infection.

Pathology of Tularemia

American Medical Association, Chicago

Gross lesions of tularemia vary somewhat in different animals. In the guinea pig they resemble bubonic plague. The site of infection is necrotic; the contiguous lymph glands are hemorrhagic or caseous, while the secondary chain of lypmh glands may be caseous.

Lesions are found chiefly in the regional lymph nodes, spleen, liver, lungs and kidneys. The disease is essentially a necrotizing process which causes areas of focal necrosis. Such areas may be small as in the liver and spleen. The spleen may be thickly studded with miliary necrotic granules, so thick that at times large areas of the spleen are necrotic. In the lungs, early roentgenograms present a cloudiness; the subsequent pulmonary abscesses are large and necrotic.

Diseases Transmitted From Animals to Man

American Medical Association, Chicago

Several score of infections and infestations are transmitted from animals to man. The cow is a prolific source of such diseases, the most serious

being tuberculosis and brucellosis. The horse spreads glanders, anthrax, encephalomyelitis and half a dozen other diseases. The hog is responsible for trichinosis, swine erysipelas and numerous other troubles. Sheep and goats spread several diseases, among the most serious of which is brucellosis. The dog, because of his intimate contact with man, is responsible for many infections, rabies being the most serious. The cat likewise has intimate contact with children and is responsible for a dozen diseases. The rat is public enemy number one with bubonic plague leading all other infections. Other rodents, which transmit diseases, include rabbits, ground squirrels, tree squirrels, chipmunks, prairie dogs, woodchucks and muskrats. Poultry and other birds transmit several diseases, the most serious being psittacosis from parrots and other pet birds. Many wild animals harbor diseases which might infect man, but the rather remote contact prevents most such infections.

Botulism

American Medical Association, Chicago

Clostridium botulinum is widely distributed in the soil everywhere. It produces the most powerful poison known, being twenty times more powerful than cobra venom, 300 times more powerful than strychnine and 10,000 times more powerful than potassium cyanide.

There are several types of the organism, type A causing most of the American outbreaks from canned foods. Since 1899, there have been 284 outbreaks of botulism, of which 267 were due to home canned foods. For nearly twenty years there have been no cases of the disease, with one possible exception, attributd to commercially canned food. Among the foods canned at home, string beans lead all the rest and are responsible for more than one-third of the outbreaks.

Botulism is an intoxication and not an infection. It has an incubation period of from one to two days with a gradual onset. Vomiting occurs in about one-third of the cases. Diarrhea is uncommon, and abdominal pains are absent. The temperature is subnormal. The nervous system is involved with double vision, difficulty in swallowing, weakness, and respiratory paralysis. The symptoms are protracted and progressive with convalescence slow. The mortality in American cases has been 65 per cent.

Hearing Aids, Their Use and How They Work

Council on Physical Therapy, American Medical Association, Chicago

Hearing aids are becoming more popular for helping the hard of hearing to understand speech. The modern vacuum tube hearing aid is essentially a small radio set, but so compact that it may be carried conveniently on one's person. Small batteries energize the set and are carried in the pocket. The vacuum tube hearing aid has been developed within the last five years. Some physicians may not have had the time to keep abreast with the developments. In this exhibit, an opportunity is provided to study some of the problems associated with the hearing aids. By means of charts and apparatus the make-up and physical characteristics of a hearing aid will be described. Demonstrational lectures will be presented at announced hours. The hearing aid will be dissected, as it were, and each component part described in simple language. Problems relating to fitting of hearing aids, servicing of them, and availability of batteries will be considered.

Endocrine Regulation of Growth

W. O. Thompson, associate professor of medicine, University of Illinois College of Medicine, Chicago; and N. J. Heckel, Chicago; and Lieutenant R. P. Morris, Chicago

This exhibit will illustrate variations from the normal in growth associated with hypofunction and hyperfunction of glands of internal secretion, with special emphasis on stimulation of growth with chorionic gonadotropin and sex hormones. It will be shown that except for the thyroid hormone in patients with childhood myxedema, chorionic gonadotropin and male sex hormone are the most potent stimulators of growth available at present. They stimulate not only the growth of the skeleton, but also the growth of every tissue in the body, in particular the musculature. They are, in other words, general growth stimulators.

Degenerative and Pathologic Changes in Lumbosacral Intervertebral Disks

R. K. Ghormley, professor of orthopedic surgery, University of Minnesota Graduate School, Rochester; and M. B. Coventry, Rochester

This is an exhibit of lumbosacral disks through the various decades of life showing degenerative changes and pathologic specimens of disks which have been removed at autopsy.

Kraurosis Vulvae and Allied Affections

L. M. Randall, associate professor of obstetrics and gynecology, University of Minnesota Graduate School, Rochester; and M. C. Piper, assistant professor of medicine, University of Minnesota Graduate School; and L. A. Brunsting, assistant professor of dermatology and syphilology, University of Minnesota Graduate School, Rochester

This exhibit consists of wax models, colored photographs, photomicrographs, and short histories and findings demonstrating kraurosis and allied lesions of the vulva.

Use of Fascia Lata in Repair of Hernias

James C. Masson, professor of surgery, University of Minnesota Graduate School, Rochester

This is an exhibit of models, transparencies, photographs, and instruments showing the technic of obtaining the preparation and the use of living sutures (fascia lata) in the repair of various types of hernias, such as inguinal hernias, postoperative abdominal hernias, diaphragmatic, umbilical and vaginal hernias.

Diagnosis of Addison's Disease

E. J. Kepler, associate professor of medicine, University of Minnesota Graduate School, Rochester; and M. H. Power, Ph. D., and F. J. Robinson, Rochester

This is an exhibit illustrating methods adapted to the diagnosis of Addison's disease, with special attention paid by the exhibitor to the "water test."

Some Relationships of the Thyroid and Pituitary Glands to Iodine Metabolism

A. S. Chapman, Rochester; and S. F. Haines, associate professor of medicine, University of Minnesota Graduate School, Rochester

This is an exhibit demonstrating results obtained in a study of certain thyroid pituitary relationships in experimental animals, data showing that iodine in the thyroidless animal has a significant effect on growth and basal metabolic rate, and evidence indicating that the thyroid may respond to the stimulus of low iodine in the absence of the pituitary gland. Photomicrographs of pituitary glands demonstrate that different iodine levels in the body may affect the hypophysial cytology in the absence of the thyroid gland.

Wisconsin Radiological Society

The Section on Radiology of the Society will present a series of exhibits in three booths at the meeting. Radiologic studies will be presented by individual members of the Section. It is anticipated that upwards of sixty radiographs will be included in the exhibit.

Diseases of Gynecological System

Arnold S. Jackson, Jackson Clinic, Madison

This is an exhibit of moulages, transilluminated colored drawings, roentgenograms, and photographs showing: (1) Gynecologic anatomy with simple views of the uterus and ovaries, illustrations of the blood circulation and lymphatics with drawings of the gential organs in relation to the pelvis. (2) Diseases of the uterus, illustrated by wax models prepared from the original specimens removed at time of operation. Cancer of the uterus, a sessile submucous tumor, myoma with cystic degeneration, and a multiple fibroid tumor are shown. A series of drawings—sagittal section of the pelvis depicts cases of malpositions of the uterus with that of the normal. (3) Diseases of the ovaries are shown by wax models and drawings as studies of the different types of ovarian cysts and tumors. (4) Diseases of the fallopian tubes, specific and nonspecific, with illustrations of different types. Plates showing diagnostic method of lipidol injection into the genital organs. (5) Cesarean section followed by abdominal hysterectomy presented by drawings in surgical step form used in the particular method of this operation. Wax models made of the fibroid tumor and placenta and photograph taken of the living baby at time of the operation.

Rationale of Bile Salt Therapy

A. C. Ivy, professor of physiology and professor of pharmacy, Northwestern University Medical School, Chicago

This is an exhibit of charts, posters, and graphs illustrating the results obtained from the administration of various therapeutic substances such as bile salts, alcohol, cinchophen, and others. Correlation of these results with medical problems in liver, gallbladder, and biliary tract disease will be made. Roentgenograms of the gallbladder under the action of various emptying substances will be shown. The effect of blood flow on the formation of bile and a model of a thermostromuhr will be demonstrated. There will be a display of all the known and currently used bile salts, both synthetic and naturally isolated.

Obstetrical Hemorrhage

F. H. Falls, professor of obstetrics and gynecology, University of Illinois College of Medicine, Chicago

The exhibit consists of models, charts, and drawings depicting the etiology, diagnosis, and treatment of various forms of obstetric hemorrhages. The models and drawings are for the most part life size and in color. The models are made in bas relief and cover in detail placenta previa, premature detachment of the placenta, postpartum hemorrhage, and hemorrhage incidental to various forms of abortion. Various forms of antepartum fetal hemorrhage are also shown. Ruptured uterus and the treatment of the associated shock and hemorrhage is presented.

The principles on which the management of obstetric hemorrhage depend are presented in the form of lettered charts, as well as statistic material.

The purpose of the exhibit is to furnish to medical men, graduate and undergraduate, and to nurses authentic information regarding the etiology, pathology, diagnosis, and treatment of obstetric complications associated with abnormal hemorrhage, to the end that they may find themselves better equipped to combat these serious emergencies, which in many if not most cases present them-

selves to the medical attendant without warning and in which speedy application of the proper remedies is the essence of treatment.

Medical Treatment of Civilian Gas Warfare Casualties

E. L. Belknap, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee; and A. R. Curreri, assistant professor of surgery, University of Wisconsin Medical School, Madison

The object of this exhibit is to show the members of the State Medical Society the amount of destruction resulting from enemy planes employing gas for a few seconds. The gases that the enemy may employ will be demonstrated. Colored lantern slides will show the gross and microscopic pathologic changes resulting from a chemical warfare attack.

It is obvious that a small exhibit can not completely discuss the treatment of these casualties. However, several posters will be presented which will ask questions relative to first aid and treatment. Anyone capable of answering these questions need not attend the postgraduate school on chemical warfare. On the other hand, those who are unable to answer these questions owe it to their communities, their patients, and themselves to attend the postgraduate chemical warfare schools that will be given in various cities of the state the latter part of September and first part of October.

Radiological Technic Demonstrations

Wisconsin Anti-Tuberculosis Association

The WATA exhibit this year will be a three-panel exhibit with a table and attendant in the foreground, the whole affair presenting some results of the Induction Center Referral Service for Wisconsin boys rejected from the armed services.

The center panel will display two or more pictographic charts showing reported causes of rejection from several thousand young men and the percentages referred to various agencies, with the great majority being referred to family physicians. Numerical breakdowns of referrals to physicians will serve as a sort of Gallup poll of existing patient-physician relationships of this group. Those under medical care, those referred to a physician of choice, referrals to the Milwaukee County Physicians Service Bureau, and those referred to a public health nurse or department for steering to a local physician are some of the significant divisions.

The two side panels will show a man in uniform and the headline, "We know what happens to these," and a man rejected at induction with the headline, "but what happens to these?" The figures may be either life-sized cardboard silhouettes or fully dressed clothiers' models.

Examples of history cards, referral slips, and the resulting key-sort-card file in which the information is correlated will be shown. A special file of tuberculosis cases, their referrals, follow-ups, and eventual disposals will also be presented at the table.

Vocational Training of the Blind

Mr. R. E. Long, Superintendent, School for the Blind, Janesville

The Braille System. Contrary to popular opinion, this is not a system of raised print-letter outlines but is a system of embossed dots. Out of a combination of six dots, the letters of the alphabet, signs, symbols, etc., are made up for reading and writing, mathematical notation, and musical scores. Methods of writing and samples of printed braille material will be presented.

Special Equipment. Educational methods for teaching visually handicapped students are much the same as in the public schools, except that one must keep in mind that much knowledge gained by the average youngster through the eyes must be secured by the blind student through the sense of touch. Equipment will be shown such as wooden maps, with removable states and countries, specially surfaced to show physical differences. Some models will be shown which are "pictures" to blind students.

In the recreational field, especially adapted games and playing cards marked in braille will be shown.

Vocational and Industrial Training. In these fields, the school includes work in basketry, chair seating, rug weaving, broom and brush making, typing and dictaphone, cooking and sewing. Completed projects and demonstrations will be presented from these departments.

Medical Program. In addition to the educational program, the school strives to maintain a complete program of general medical services, with particular emphasis on the preservation and restoration of vision. Charts and statistics will be presented showing frequency and causes of blindness, in addition to disease prevention by tests and immunizations.

School authorities in attendance at the exhibit welcome you and will be glad to answer any questions about the school and work for the blind in general.

Obstetric Manikin Demonstrations

Wisconsin Society of Obstetricians and Gynecologists. William F. Mengert, associate professor of obstetrics and gynecology, State University of Iowa College of Medicine, Iowa City; Morris E. Davis, associate professor of obstetrics and gynecology, University of Chicago, The School of Medicine, Chicago, and Carl P. Huber, associate professor of obstetrics, Indiana University School of Medicine, Bloomington–Indianapolis

At the invitation of the Wisconsin Society of Obstetricians and Gynecologists, W. F. Mengert, M. E. Davis, and C. P. Huber will, in accordance with the

schedule set forth below, demonstrate and discuss with registrants at the meeting the subjects selected by R. E. Campbell and W. C. Keettel, under whose supervision the exhibit was arranged. All demonstrations will be conducted in the scientific exhibit hall.

Morning discussion each day will be devoted to an explanation of the use of forceps, demonstrating the various types of forceps and the indications and contraindications for their use, including the management of occiput posterior and the various methods of treating this presentation.

The afternoon demonstration period each day will be limited to a discussion of the management of breach presentation with a demonstration of the various methods of delivery, also a discussion of version and extraction.

Monday—September 13
10:00–10:30 a.m.
3:00– 3:30 p.m.
William F. Mengert

Tuesday—September 14
10:00–10:30 a.m.
3:00– 3:30 p.m.
Morris E. Davis

Wednesday—September 15
10:00–10:30 a.m.
11:30–12:00 a.m.
Carl P. Huber

Technical Exhibitors at One Hundred Second Anniversary Meeting

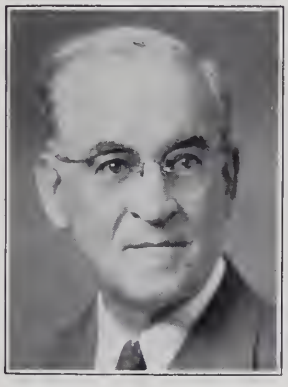
The Borden Company, New York, New York
Bilhuber–Knoll Corporation, Orange, New Jersey
Rudolph Beaver, Inc., Waltham, Massachusetts
Belgard–Spero, Inc., Milwaukee
S. H. Camp and Company, Jackson, Michigan
The Carnation Company, Oconomowoc
C I B A Pharmaceutical Products, Inc., Summit, New Jersey
Coca Cola Company, Atlanta, Georgia
Conformal Footwear Company, St. Louis
General Electric X-Ray Company, Chicago
Gerber Products Company, Fremont, Michigan
H. J. Heinz Company, Pittsburgh, Pennsylvania
Horlick's Malted Milk Corporation, Racine
Hurley X-Ray Company, Milwaukee
Mead Johnson Company, Evansville, Indiana
Kelley–Koett Manufacturing Company, Covington, Kentucky
The Kellogg Company, Battle Creek, Michigan
Kremers–Urban Company, Milwaukee
Lederle Laboratories, New York, New York
Eli Lilly and Company, Indianapolis, Indiana
J. B. Lippincott Company, Philadelphia
M and R Dietetic Laboratories, Columbus, Ohio
Medico-Mart, Milwaukee
Mellin's Food Company, Boston, Massachusetts
Wm. S. Merrell Company, Cincinnati, Ohio
Philip Morris and Company, New York, New York
C. V. Mosby Company, St. Louis
V. Mueller and Company, Baltimore, Maryland
Pet Milk Sales Corporation, St. Louis
Petrogalar Laboratories, Inc., Chicago
Physicians and Hospitals Supply Company, Minneapolis
Roemer Drug Company, Milwaukee
Sandoz Chemical Works, Inc., New York, New York
W. B. Saunders Company, Philadelphia.
Schering Corporation, Bloomfield, New Jersey
G. D. Searle and Company, Chicago
Sharp and Dohme, Philadelphia
Smith, Kline and French Laboratories, Philadelphia
S. M. A. Corporation, Chicago
E. R. Squibb and Sons, New York, New York
U. S. Hospital Supply Company, Minneapolis
U. S. Standard Products Company, Woodworth.
White Laboratories, Inc., Newark, New Jersey
Winthrop Chemical Company, Inc., New York, New York
John Wyeth and Brother, Inc., Philadelphia

OFFICERS

STATE MEDICAL SOCIETY OF WISCONSIN

R. M. KURTEN
Racine
President

CHARLES FIDLER
Milwaukee
Speaker



P. R. MINAHAN
Green Bay
Vice-Speaker

I. R. SISK
Madison
Treasurer

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STATE MEDICAL SOCIETY OF WISCONSIN

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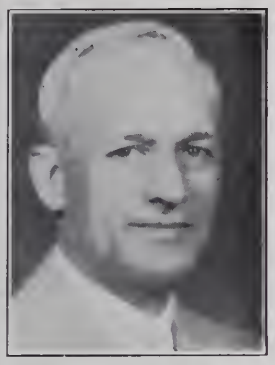
Kenosha
Councilor, 2nd District

W. T. CLARK
Janesville
Councilor, 3rd District

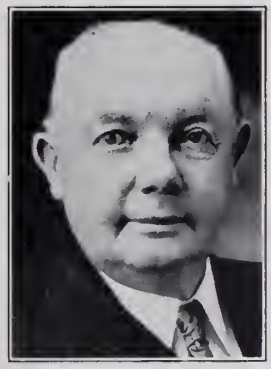
B. I. PIPPIN
Richland Center
Councilor, 4th District

A. H. HEIDNER
West Bend
Councilor, 5th District

H. A. JEGI
Galesville
Councilor, 7th District



G. W. KRAHN
Oconto Falls
Councilor, 8th District



H. H. CHRISTOFFERSON
Colby
Councilor, 9th District

R. G. ARVESON
Frederic
Councilor, 10th District

V. E. EKBLAD
Superior
Councilor, 11th District

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Park Falls
Councilor, 13th District

GUNNAR GUNDERSEN
La Crosse
Past-President

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. E. S. Schmidt, Green Bay, President
Mrs. H. E. Twohig, Fond du Lac, President-Elect
Mrs. R. B. Dryer, Poynette, Vice-President
Mrs. R. M. Kurten, Racine, Recording Secretary
Mrs. L. D. Quigley, Green Bay, Corresponding Secretary
Mrs. Charles Fidler, Milwaukee, Treasurer
Mrs. C. D. Partridge, Cudahy, Parliamentarian

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Program—
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Public Relations—
Mrs. R. D. Champney, Milwaukee
Legislation (special committee)—
Mrs. L. V. Sprague, Madison
Circulation of Bulletin (special committee)—
Mrs. W. A. Wagner, Oshkosh
War Activities (special committee)—
Mrs. A. J. McCarey, Green Bay

All Doctors' Wives, Welcome!

A MOST cordial invitation is extended to every doctor's wife, whether or not she is a member of the Auxiliary, to participate in the social functions and attend the business sessions of the fifteenth annual meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin.

Due to wartime conditions, all meetings will be held at the Hotel Schroeder, Milwaukee, September 12, 13 and 14.

Attendance at luncheons and other social events will be by ticket only. To enable our hostesses, members of the Milwaukee County Auxiliary, to make adequate preparations, please register early. The convention chairman, Mrs. H. O. Zurheide, 2470 North Sherman Boulevard, Milwaukee, will greatly appreciate receiving early reservations for tickets by mail.

Our guests of honor will be Wisconsin's three national officers: Mrs. E. J. Carey, president; Mrs. Charles Fidler, corresponding secretary; and Mrs. O. W. Friske, program chairman. At the Monday evening reception, Auxiliary members will offer felicitations to these loyal co-workers who have achieved national recognition.

We are proud to present as our luncheon guest speaker on Monday, Rear Admiral Ross T. McIntire, Surgeon General of the United States Navy, Washington, D. C., who will discuss some phase of the care of personnel. Admiral McIntire will be introduced by Dr. Russell M. Kurten, president of the State Medical Society of Wisconsin.

Mrs. E. S. Schmidt, Green Bay
President

At the Tuesday luncheon, Mrs. Carey, speaking as national president, will discuss new program plans, emphasizing our contribution to the War Participation Program recently inaugurated.

Other speakers will also be presented, and a number of entertainment features have been planned by Milwaukee members.

On Tuesday evening, the annual informal dinner for physicians and their wives will be held in the Crystal Ballroom. The speaker will be Dr. James E. Paullin, president of the American Medical Association. His subject will be "The Role of the Medical Profession in Planning for Post-War Medical Service."

I earnestly urge every member of the Auxiliary to plan now to leave her many worries and duties behind and enjoy a few days of pleasant and profitable association with friends of the State Auxiliary.

MARY M. SCHMIDT
President

Mrs. H. E. Twohig
Fond du Lac
President-Elect

Mrs. H. O. Zurheide
Milwaukee
Convention Chairman

PRELIMINARY PROGRAM

Sunday, September 12, 1943

P. M.

4:00–7:00 Registration — Hotel Schroeder, Fifth Floor

7:00 Board of Directors' Dinner—Hotel Schroeder
Mrs. E. S. Schmidt, president, presiding
Guests
Past-presidents, Woman's Auxiliary to the State Medical Society of Wisconsin
Wisconsin's three national officers: Mrs. E. J. Carey, Wauwatosa, president; Mrs. Charles Fidler, Milwaukee, corresponding secretary; Mrs. O. W. Friske, Beloit, program chairman
Reports of state chairmen

Monday, September 13, 1943

A. M.

10:00 General Meeting — Club Rooms, Hotel Schroeder
Mrs. E. S. Schmidt, president, presiding
Invocation—Reverend F. M. Sheldon, Grand Avenue Congregational Church, Milwaukee
Auxiliary Pledge
Convention Announcements
Address of Welcome—Mrs. F. R. Janney, president, Woman's Auxiliary to the Medical Society of Milwaukee County
Response — Mrs. H. E. Twohig, president-elect, Woman's Auxiliary to the State Medical Society of Wisconsin
In Memoriam
Convention Rules and Procedure—Mrs. C. D. Partridge, parliamentarian
Minutes of Annual Meeting, 1942
Reports of State Officers
Reports of County Auxiliary Presidents
Report of Chairman, Committee on Credentials and Registration
Address—"Activities in the State Office"—Mr. C. H. Crownhart, secretary, State Medical Society of Wisconsin
Announcements

P. M.

1:00 Luncheon—Crystal Ballroom, Hotel Schroeder
Greetings — Dr. R. M. Kurten, president, State Medical Society of Wisconsin
Address—A Review of the Accomplishments Made in Lifesaving by the Medical Corps of the Navy in the Present War — Rear Admiral Ross T. McIntire, Surgeon General of the United States Navy, Washington, D. C.

7:00 Buffet Supper and Reception—Banquet Room, Hotel Schroeder (Courtesy, State Medical Society of Wisconsin)
Guests of Honor—Mrs. E. J. Carey, national president, and her national board members, Mrs. Charles Fidler and Mrs. O. W. Friske
Entertainment—Mrs. Myra Peache
Current New York Plays
Music

Tuesday, September 14, 1943

A. M.

10:00 General Meeting — Club Rooms, Hotel Schroeder
- Mrs. E. S. Schmidt, president, presiding
- Business Session
- Election of Officers
- Induction of the President, Mrs. H. E. Twohig
- Installation of New Officers
- Announcements
- Report of Chairman of Committee on Credentials and Registration

11:30 Post-Convention Meeting—Board of Directors —Club Rooms, Hotel Schroeder
- Mrs. H. E. Twohig, president, presiding

P. M.

1:00 Luncheon—Banquet Room, Hotel Schroeder
- Round-Table Discussions of Auxiliary Activities
  - County Presidents — Mrs. F. R. Janney, Milwaukee
  - Treasurers — Mrs. Charles Fidler, Milwaukee
  - Archives—Mrs. J. P. Connell, Fond du Lac
  - Finance—Mrs. J. R. Minahan, Wauwatosa
  - *Hygeia*—Mrs. A. C. Taylor, Appleton
  - Philanthropic—Mrs. S. O. Lund, Cumberland
  - Program—Mrs. D. F. Gosin, Green Bay
  - Press and Publicity—Mrs. D. B. Dana, Kewaunee
  - Public Relations—Mrs. R. D. Champney, Milwaukee
  - Circulation of *Bulletin*—Mrs. W. A. Wagner, Oshkosh
  - Legislation—Mrs. L. V. Sprague, Madison
  - War Activities — Mrs. A. J. McCarey, Green Bay
- Address—"The Auxiliary War Participation Program" — Mrs. E. J. Carey, national president
- Entertainment—Miss Nancy Gray, commentator, Radio Station WTMJ
- Music

6:45 Informal Banquet, State Medical Society of Wisconsin — Crystal Ballroom, Hotel Schroeder
- "The Role of the Medical Profession in Planning for Post-War Medical Service"—Dr. James E. Paullin, president, American Medical Association

Register by Mail

To enable convention hostesses to make adequate preparations, registration by mail in advance of the meetings will be appreciated. You may fill in the form shown below and mail it to *Mrs. H. O. Zurheide, 2470 North Sherman Boulevard, Milwaukee, Wisconsin.*

Name _____

Address _____

Number of Reservations Desired:

Monday Luncheon, $1.50 _____

Tuesday Luncheon, $1.50 _____

Monday Supper and Reception _____

(Please include name and address of any guests. All persons attending functions must be registered.)

DO YOU NEED BATTERIES?

As a service to members of the Society, arrangements have been made to secure a supply of flashlight batteries for use by physicians in the discharge of their professional duties. Virtually the entire output of the battery manufacturers is assigned to military orders. A part of the small amount allocated for civilian use has been made available by the Ray-o-Vac Company for distribution to physicians without profit to the Society. The management of the Ray-o-Vac Company recognizes the essentiality of using batteries in the physician's practice.

If you need batteries for your otoscope, opthalmoscope, or for flashlights used in other examining instruments, fill in the order blank below and forward it to the Society's office:

Mr. C. H. Crownhart, Secretary
State Medical Society of Wisconsin
917 Tenney Building
Madison (3), Wisconsin

Please enter my order for the following batteries which will be used by me for diagnostic or treatment purposes.

Penlight Batteries (7R) _____ _____
Quantity

Standard No. 2 Size _____ _____
Quantity

_____ M. D.

Annual Reports of the Officers and Committees to the 1943 House of Delegates

1. REPORT OF THE COUNCIL

Minutes of the Council meetings held since September, 1942, have been published in *The Wisconsin Medical Journal* and have been made available through that medium to the membership of the State Medical Society. Pursuant to custom, no effort is made in this report to summarize the proceedings of the Council over this period of time, as it is presumed that the delegates have noted them as printed and will, themselves, be prepared to offer suggestions constructive to the purposes of the Society. The chairman of the Council will amplify the printed report when the House of Delegates is in session.

The Council reports a satisfactory "state of the nation" within the House of Medicine in Wisconsin. Despite difficult circumstances that have confronted the medical profession in its participation in the war effort of the nation, a greater percentage of members than under ordinary circumstances have lent their shoulders to the wheel that the progress of public health movements in Wisconsin might not be either halted or delayed. In similar manner have they contributed directly to the war effort, and it is with a special pride in the profession its members represent that the Council notes the cooperation that has been forthcoming from the individual physicians of the State of Wisconsin.

Specifically, the Council has suffered the loss by death in the interim between sessions of the House of Delegates of one of its members, Dr. T. J. O'Leary of Superior, councilor from the Eleventh District, and the loss by resignation of another of its members, Dr. J. W. Lambert of Antigo, who entered the service of his country and is now stationed at Fitzsimons General Hospital, Denver, Colorado. Pursuant to the mandatory provision of the By-laws, the Council has appointed to fulfill the unexpired terms of these two members Dr. J. D. Leahy of Park Falls and Dr. V. E. Ekblad of Superior and calls the particular attention of the House of Delegates to the fact that it has discharged its obligation in this respect.

Without any apparent or real involvement of Society affairs, Dr. R. M. Kurten of Racine has succeeded to the office of president of the State Medical Society as a result of the death of the incumbent president, Dr. Francis E. Butler of Menomonie.

The Council feels that the members of the House of Delegates should note that despite these losses in the leadership of organized medicine within the state, the program of the State Medical Society of Wisconsin has continued to be constructive, realistic and vigorous.

Because of the current involvement of the nation in World War II, the Council has been thoroughly sympathetic to the fact that changing conditions of the year, or even of the day or month, may necessitate the reforming of the ranks of medicine to new causes when those causes suddenly are catapulted into fields of unusual importance. It has conceived its responsibility to lend all aid necessary to the successful program of the Procurement and Assignment Service in Wisconsin and to that end has dedicated its efforts and much of its time, both in session and informally, throughout the year.

The Council noted also that the problems of county medical societies were complicated by the loss of members to the armed service as well as by the situation developing out of the fact that many young men are entering service directly upon graduation from medical schools and without opportunity to join a local county medical society and without the opportunity of the local profession to know them. For this reason and acting under unusual powers specifically granted to it by the Constitution and By-laws, the Council at its annual meeting in January, 1943, adopted the following amendment to the By-laws of the State Medical Society of Wisconsin, which it now desires the House of Delegates to ratify:

Section 11, Chapter X of the By-laws of the Society is created to read as follows:

"Section 11. This Society shall recognize as a special service member any physician who is in the armed forces of the United States, who has been licensed to practice medicine and surgery in Wisconsin, and who has not previously been a member of any county medical society. Such physician shall first have been accepted as a special service member by a component county society in accordance with the provisions of its Constitution and By-laws, and the fact of such membership certified to this Society. Application for such special service membership shall not be dependent upon the place of previous residence or the place or period of previous practice, and such membership shall include all the rights and privileges of active membership excepting those of voting and holding office.

"No dues shall be assessed against such member until the month following his discharge from the armed forces of the United States, at which time he shall pay prorated dues for the balance of the calendar year of his discharge from service. Special service membership shall lapse at the close of the calendar year of the discharge of each such member from service."

Other matters of particular concern have faced the Council during this year. In the light of immediate necessity, the Council has authorized appointment by its chairman of a Committee on War Records, of a committee advisory to the Veterans Recognition Board, and of a committee advisory to the State Board of Medical Examiners relative to the Medical Practice Act. As to the first two matters, the Council notes the desirability of maintaining the

war records of Wisconsin physicians and the need, also, of maintaining the continued cooperation of the physicians in the cause of veterans' rehabilitation. Because statutory procedures on a state level were deemed advisable, the 1943 session of the legislature created a special group known as the Veterans Recognition Board, which numbers among its members Dr. C. A. Dawson of River Falls, secretary of the State Board of Medical Examiners and chairman of the Society's Committee on Public Policy. Acting upon his suggestion and in full appreciation of the immediate need confronting that Board, the Council in July, 1943, authorized appointment of a special committee to be composed of three members.

As every physician in the state doubtless knows, under the sponsorship and authorization of the State Medical Society the 1943 legislature passed, and the Governor of Wisconsin signed, a measure calling for annual registration of physicians. Probably no matter of such vital concern has been adopted in any year since the enactment of the Basic Science Law. The Council notes with pride the accomplishment of the passage of this measure and feels that in its realistic and practical approach to the public health problems of the state, this measure will contribute to significant progress. The Council recognizes also that in its development and in its planning of functions under this measure, the State Board of Medical Examiners is confronted with perplexing problems of great detail and of most serious moment to the medical profession and to others involved.

Carrying out its extensive policy of cooperation developed so carefully over the last several years, your Council in the name of the Society has extended its pledge of cooperation to the State Board of Medical Examiners and, to implement that cooperation with procedures of practical importance, has instructed the appointment of a special advisory committee to that Board and has authorized your secretary to employ special and competent legal counsel to present to that board the views of the medical profession in any matter in which it may be properly and extensively involved in the administration of that new law. This procedure has just been undertaken, and, pending its further development, the Council can do no more than report that fact to the House of Delegates and the membership at the present time.

Before concluding this report with the recording of the deaths of members of this Society since the last annual meeting, your Council is most concerned that it express adequately and with all the sincerity at its command its belief that in the activities of the Society a constructive and infinitely involved but realistically planned program has been developed. The cooperation that has come about between those state agencies concerned with various public health problems of this state, most of which agencies were created at the suggestion of this Society and have shown every evidence of a cooperative attitude which recognizes their representative capacities as agencies of public health in this state, is noteworthy. Significant strides have been accomplished in this field, and the Council feels that each year denotes the outstanding progress which again confirms the view that medicine never stands still but constantly moves ahead.

Report on Necrology

The Council has the sad duty of reporting the deaths of the following physicians since the last anniversary meeting. Members of the Society are indicated by boldface type.

Baird, John ____ Superior
Baker, Glenn L. ____ Rib Lake
Baldwin, Fayette H. ____ Bloomington
Becker, Bernard A. ____ Silver Lake
Beier, Anton D. ____ Milwaukee
Bergholz, Eugene A. ____ Milwaukee
Beyer, Christian H. ____ Milwaukee
Bossard, Clemens ____ Richfield
Bussewitz, Maxillian A. ____ Milwaukee
Butler, Francis E. ____ Menomonie
Campbell, Bernard L. ____ Milwaukee
Cole, Bedau A. ____ Thorp
Conley, John Mayo ____ Oshkosh
Crane, Marlin C. ____ Wittenberg
Dean, Joseph ____ Madison
Del Marcelle, Clarence C. ____ Green Bay
Dobson, Hervie A. ____ Madison
Ericksen, Hans C. ____ Soldiers Grove
Ernst, George R. ____ Milwaukee
Fairfield, W. E. ____ Green Bay
Falbe, Carl A. ____ Richfield
Farnsworth, Frank B. ____ Janesville
Fleischer, Herman F. ____ Clintonville
Gordon, John B. ____ Shawano
Gunther, Emil ____ Sheboygan
Harkness, Grove ____ Waukesha
Hartman, Sergius A. ____ Milwaukee
Hilger, William F. ____ Milwaukee
Hines, L. L. ____ Richland Center
Henrichsen, James A. ____ Larsen
Horwitz, J. J. ____ Milwaukee
Hougen, Edward ____ Wisconsin Rapids
Jarvis, Edward ____ Madison
Jones, David T. ____ Wausau
Kelly, Clarence A. ____ St. Croix Falls
Konop, Edward J. ____ Sawyer
Laird, John J. ____ Black Creek
Lansdowne, Frank B. ____ Kenosha
Lawler, Edward M. ____ Cudahy
Layton, Oliver M. ____ Fond du Lac
McQuillin, Henry C. ____ Madison
Mauermann, Julius F. ____ Monroe
Meachem, John G. ____ Racine
Mehigan, David D. ____ Milwaukee
Muenzer, Richard J. ____ Milwaukee
Munger, Deo C. ____ Ellsworth
Neilson, George W. ____ Milwaukee
O'Leary, Thomas J. ____ Superior
Oliver, Thomas J. ____ Green Bay
Pomainville, George J. ____ Nekoosa
Prill, Herman F. ____ Augusta

Raasoch, Halfdan ----------Nelsonville
Rosenberg, C. F. ----------Milwaukee
Sarazin, Frank C. ----------Superior
Schlaikowski, Joseph P. ----------Wausau
Sexton, Walter G. ----------Marshfield
von Neupert, Carl ----------Stevens Point
Vedder, Harry A. ----------Marshfield
Walters, Perry A. ----------La Crosse
Werner, Nels ----------Eau Claire
Wenn, Julius F. ----------Milwaukee

2. REPORT OF THE SECRETARY

The secretary of your Society functions in a secretarial capacity to the activities under the direction of your Council, your officers, and your various committees. Thus, in a sense, the committee reports following account for many of your secretary's activities during the last year.

In your secretary's estimation, there is no single effort of the Society that stands out among all others. The year itself, however, has been most outstanding in the concrete accomplishments it has seen in the field of public health, and your secretary feels it is most opportune at this time to express a grateful recognition on behalf of the State Medical Society of Wisconsin for the substantial assistance given by the various members of the Society during the last year.

The Central Office

Your secretary also wishes to commend to the attention of the members the fact that the work of the central office is implemented by an exceptionally well trained, devoted staff which has ever the interests of the office at heart. Its constructive assistance and willingness to work during these periods of extraordinary strain and under circumstances that could only be at great personal inconvenience to themselves is a fact not alone worthy of comment but of special note in this report to the members of the State Medical Society.

No office such as that of your secretary can function without a basic philosophy. A philosophy is not conceived but is developed, and only over a sufficient period of time may it arrive at a mature status, shaped and directed through the efforts of many members of the organization. Every effort has been made in your secretary's office to continue those basic policies which, over the period of eighteen years prior to the summer of 1941, had so been developed and nurtured. But a statement of that philosophy might well be apropos at this time. Basically, it is that the State Medical Society articulates into a single voice the opinions and expressions of the medical men of Wisconsin. It represents the voice of the majority, for in a democratic country that voice is the voice which governs. It represents no single element, no class distinction, no particular group, and no geographic distribution of its physician members. It serves the cause of public health and, in serving that cause, is the agent of its individual members. It must epitomize the dignity of the individual professional man; it must clothe itself with his integrity, his devotion to a cause, his willingness to work to an extent that can only be self imposed. For its activities, it must account to all, and these it must serve and serve well.

It must respect the confidence of its members. It must serve as an agency which fuses the thoughts of the medical men and causes their activities to be concerted, consistent, and effective.

To that exposition of the function of the central office are the efforts of your secretary dedicated. Within the common limits of mankind to maintain its consistency and its point of view, your secretary pledges his continued effort to that cause.

Medical and Surgical Clinics

Your secretary feels that it is not amiss here that he stress several activities of noteworthy importance during the last year. By direction of the House of Delegates, as well as by popular demand, the Society undertook, in cooperation with other organized agencies, to provide postgraduate medical and surgical clinics in the field of industrial health. It sought at all times to encourage the development of these clinics as essentially locally sponsored and locally endorsed public health procedures, and your secretary is able to state that in the three communities of Appleton, Madison, and Milwaukee, the functions of these clinics were well received and redounded to the benefit of advancing the public health along the lines indicated.

Procurement and Assignment Service

Possibly no matter has been of greater concern to the individual professional man than his obligation to his community and to his country in this time of war. It is with pardonable pride that one who is not a member of the medical profession may assert to the profession and to the public that the cooperation of the medical profession surpasses anything that could possibly have been expected of it in the imminent days of the present conflict. The Procurement and Assignment Service, under the direction of the state chairman, and with the advice that has been made available to him by leaders in the medical profession throughout the state, has been outstanding in its cooperative attitude and practical understanding of the various problems involved. It is your secretary's firm conviction that, speaking of Wisconsin of which he has personal knowledge, the directing officers of the Procurement and Assignment Service at the state level have at all times endeavored to convey to the physicians of the state the true and absolute facts confronting them that they might themselves, and for themselves, determine the procedures indicated.

It is not conceivable to the secretary that anyone unacquainted with the immensity of the task confronting the Procurement and Assignment Service, the untold hours of devoted labor given to personal interviews and careful consideration of individual problems, and to the reconciliation of the needs

of the nation versus the needs of the community, could possibly appreciate the extent to which the Procurement and Assignment Service may be truly characterized as an agency of integrity and soundness and one which reflects credit upon the profession which urged its creation.

In the several fields involving the relocation of physicians in Wisconsin, in Civilian Defense and in Selective Service, the work of the medical profession has been outstanding and to a point where your secretary doubts that any groups without the field of medicine can appreciate the extent of effort made by the medical men.

Other Activities

This report cannot undertake to enumerate the many responsibilities that exist in the office apart from those directly connected with committee activities. During the last year, special supplements to *The Wisconsin Medical Journal* and special bulletins to the members have been prepared and utilized to provide the membership with authentic information of major importance. Through this modality, physicians have been assisted in matters pertaining to rationing, responsibilities to make reports under state and federal laws, impending changes in state laws, and the like. The maintenance of certain routine tasks is accepted without emphasis, but is always time consuming. Thus your office acts as advertising manager for *The Journal* and, in a similar capacity, for the Annual Meeting. It must maintain the records of over 2,500 members on a year to year basis and distribute membership certificates and pocket cards. It maintains by direction informational folders on medical care facilities within the state and gives special attention to records of those in service. These and a multitude of other similar tasks provide more than sufficient activity to fill in all gaps and force the administrative machinery into "high gear" at all times.

Your secretary feels impelled to make these observations in the form of his official report to the members of the State Medical Society of Wisconsin. He makes it not only as your secretary, but as one who hears the public voice and who knows that the appreciation of the people may often be unexpressed but is nevertheless real and understanding.

Membership

In conclusion, your secretary wishes to report the membership status as of the date of August 10, 1943.

1. Fully paid members	1,963
2. Partially paid members	1
3. Members in military service who paid no dues in 1943	384
4. Members in military service who paid prorata dues in 1943	35
5. Members recently reported in service on whom correspondence is pending	31
6. Life members, honorary members, members whose dues were waived because of temporary but serious incapacity	64

3. REPORTS OF STANDING COMMITTEES

COMMITTEE ON CANCER

Charles Fidler, chairman, L. J. Van Hecke, A. L. Mayfield, C. F. Dull, J. C. Fox, W. S. Bump, Julius Blom, T. E. Malloy, J. W. McGill, E. F. Schneiders, T. A. Teitgen, Erich Wisiol, G. E. Eck, D. J. Twohig.

Cancer continues to rank as the second cause of death in Wisconsin. The Committee on Cancer has been ever mindful of this fact during the last year and has directed its activities toward the reduction of the number of deaths resulting from this disease and the mitigation of the suffering that is attendant on it.

That the profession in Wisconsin might be apprised of cancer trends in Wisconsin, the Committee on Cancer has perfected arrangements for the appearance of at least six brief articles on cancer in *The Wisconsin Medical Journal.* One article on this appeared in the June, 1943, issue of *The Journal*, and a second one is included in this issue.

The Council of the Society recommended that the State Board of Health, through the pages of *The Journal*, keep physicians in Wisconsin alert to disease trends and health matters deemed by them to be of paramount importance. Arrangements were made with Dr. C. N. Neupert to have a series of articles prepared under the direction of Dr. William C. Keettel. Articles scheduled for inclusion in future issues of *The Journal* are on the subject of cancer of the gastrointestinal tract, cancer of the breast, cancer of the female reproductive system, and the diagnosis of cancer.

Postgraduate Medical Education

Efforts were begun last year to develop a cooperative working arrangement with the Council on Scientific Work to the end that special attention be given to cancer education, either through the medium of one day scientific programs or through a repetition of the refresher courses presented several years ago.

District Cancer Meetings

The Committee on Cancer, by provision of the By-Laws of the State Society, is composed of a committeeman from each of the thirteen Councilor districts. The area served by each member of the committee is identical with the Councilor district in which he resides. The Committee on Cancer recommended that greater emphasis be placed upon the holding of district meetings by the members of the committee. These meetings were to be especially designed to be of interest to chairmen of cancer committees of county medical societies. While specific action upon this was taken at a meeting of the Committee on Cancer, the chairman of the committee forwarded to each district cancer committeeman a written request urging the holding of these meetings.

Women's Field Army

By direction of the American Society for the Control of Cancer, the personnel of the Executive Committee of the Women's Field Army is that of the personnel of the Committee on Cancer. The Women's Field Army is now in its sixth year in Wisconsin. Much of the time and effort of the committee during these years has been directed to the perfection of this organization, which has been lending it assistance, advice, and counsel. The Committee on Cancer of the Society prior to the organization of the Women's Field Army had directed long, continuous, and arduous efforts in the field of postgraduate medical education, and it was the feeling of members of the committee that while much remained to be accomplished in the scientific field, the physicians and the state were now ready to engage in an extensive lay educational program, and for this reason much of the work of the committee has been devoted to a cooperative effort with the Women's Field Army.

The American Society for the Control of Cancer each year requests a confirmation from the Executive Committee of the Women's Field Army for the appointment of its state commander. The Executive Committee confirmed the appointment of Mrs. Erma G. Stoddart of Beaver Dam as state commander for the Women's Field Army for the current year.

Memorial Funds

The policy which was established by the American Society for the Control of Cancer when they requested the assistance and the cooperation of the State Medical Society in the formation of the Women's Field Army was that this organization was to limit its efforts exclusively to educational endeavors. Specifically, the American Society for the Control of Cancer stated that they were not to engage in treatment programs.

On the basis of this stated policy, the committee recommended to the Council of the Society that active assistance be given the Women's Field Army. This assistance took the form of both a financial loan and the granting of extensive personnel assistance to the organization.

This has been the consistent policy of the Executive Committee of the Women's Field Army since the inception of the organization. On several occasions the question has arisen concerning the use of memorial funds for treatment of patients within the local community where the memorial fund originated.

Memorial funds are contributions in excess of one dollar and are earmarked for use for the purposes specified by the donor. A complete review was made of this subject during the year, by the Administrative Committee of the Women's Field Army, and they have directed that the initial policy established by the American Society for the Control of Cancer and concurred in by the Wisconsin Division of the Women's Field Army be adhered to. The work of the Women's Field Army in Wisconsin will therefore continue to limit its activities in Wisconsin to educational work.

Educational Program

The work which has been advanced by the Women's Field Army in Wisconsin may not, when considered on an individual basis, appear to be an effort of great magnitude. In the aggregate, however, it is the feeling of your committee that very extensive and material gains have been made through the efforts of the Women's Field Army to reach Wisconsin citizens and to make available to them pertinent information on cancer. There can be no question concerning the fact that many premature deaths have been averted through knowledge disseminated by this agency. Likewise, much suffering has been alleviated.

The means which are employed by the Women's Field Army to reach the public are manifold. The printed page maintains the first position and is followed by public meetings, exhibits, motion pictures, and radio.

The Executive Committee has had before it for consideration during the last year a proposed elaborate program for use in schools, particularly in biology classes, in order that children may learn early the danger signals that point to cancer and the recognized means of controlling and curing it. This program is scheduled for further consideration by the committee. The Executive Committee also considered the possible use in Wisconsin of a cancer consultant to be employed by the State Board of Health to give added impetus to the control of cancer in Wisconsin. No definite decision or conclusion has been reached by the committee on this question.

Funds

To develop further the educational program requires the expenditure of a sizable sum of money. The total amount collected during 1943 approximated that which has been collected by the organization during the last several years. As this report is written, the Women's Field Army has collected over $9,000 with an additional $1,000 to $1,500 reported by local officers of the organization but not yet remitted. In addition, memorial funds in the amount of almost $2,000 have been obtained for further educational purposes.

ADVISORY COMMITTEE ON CARE OF CRIPPLED CHILDREN

J. B. MacLaren, chairman, H. A. Sincock, H. L. Greene, J. O. Dieterle, H. C. Schumm, C. M. Kurtz.

Orthopedic Clinics

Three years ago the Advisory Committee on the Care of Crippled Children recommended that a program giving assurance of continuity be adopted by the Bureau of Handicapped Children of the State Department of Public Instruction. Prior to this

time, orthopedic clinics had been held in several communities in the state with the same patients presenting themselves to the clinic year after year. Many of these have been classified by examining orthopedists as cases that could not be benefited by further treatment. These cases then consumed the time that should properly be devoted to cases that had not had the benefit of recent orthopedic consultation.

The three year experimental program which was recommended by the committee provided that the county medical society in whose jurisdiction orthopedic schools were located select an orthopedic surgeon to serve the orthopedic school for three consecutive years. Arrangements were made so that after the orthopedist had completed his work in connection with the students enrolled in the orthopedic school, other cases might be seen. It was recommended that more stringent restrictions be placed upon those cases which might be reviewed. The conditions now in effect and employed by the Bureau of Handicapped Children are as follows:

For. The clinics conducted by the Crippled Children Division are for persons under 21 years of age.

Referral. All referrals to the clinics for examinations must be made by the family physician. We urge the parents to take their child to their physician before asking for a referral.

Referral Blanks. Blanks for the purpose of referral may be obtained from the Bureau for Handicapped Children and should be requested well in advance of the clinic date.

Clinic Appointment. When the referral blank carrying the signature of the family physician is returned to the Bureau for Handicapped Children, the family will be notified of the hour of its appointment.

Parents. Parents and physicians are invited to attend the clinic with the child. If the public health nurse feels that the child referred to the clinic for orthopedic reasons is also in need of other services, please feel free to write.

It was found that greater attention to the problems in the orthopedic school was afforded by this means and the orthopedists were better able to give assistance to the local community when these restrictions were followed. The Advisory Committee on the Care of Crippled Children recommended to the Bureau of Handicapped Children that this experimental program be extended for an additional three years.

There has arisen a demand by county medical societies for special orthopedic clinics that were not connected with orthopedic schools. The committee has recommended that an additional limited few of these orthopedic clinics be conducted.

County Society Orthopedic Committees

The committee has urged that there be appointed in each county medical society area in which is located an orthopedic school a special advisory committee to the school. The committee is happy to report that in a majority of the communities such committees do exist.

Acute Poliomyelitis

The committee, by formal action, recommended that a portion of the facilities at the orthopedic hospital be set aside for the treatment of acute poliomyelitis. An announcement was carried in *The Wisconsin Medical Journal* in the May, 1943, issue. The purpose of this recommendation was to subject to critical appraisal the thermal treatment of poliomyelitis. The report on this initial investigation appears on page 783 of this issue.

The Spastic Cripple

The committee has considered during the several previous years the problem of caring for the spastic cripple. The special attention of the committee was directed to ascertaining what facilities were available to determine the mental capabilities of the spastic child. The committee was advised that on the basis of a special study made of this question by Dr. H. Kent Tenney, medical consultant for the Bureau of Handicapped Children, that no single method is known whereby the mental capabilities of the spastic child might be appraised.

A small unit is in operation at the Washington School in Madison and is being watched by those in the teaching field, particularly in the speech departments, and by psychiatrists. One of the problems which has confronted the handling of spastic children is who is to make the decision as to the care and program for the child. Others who are watching the development of this experimental unit are the orthopedists.

The committee recommended to the Bureau of Handicapped Children that before entry to the spastic school is effected, the children should have the benefit of a thorough study at the orthopedic school.

One of the future problems of the committee is to consider the possibility of a physician especially trained to study and consult on the treatment of spastics, should such a program in the light of future developments appear to be a wise one.

Convalescent Homes

The problem with which physicians and the Bureau of Handicapped Children are confronted in connection with the care of the cardiac cripple was discussed at length in the previous report of this committee.

The advisory committee had recommended that a thorough study be made by a special subcommittee consisting of Dr. Chester M. Kurtz, Madison, and Dr. H. Kent Tenney, Madison, to investigate the possibility of establishing a convalescent home for the care of cardiac cripples. This subcommittee reported that after extensive exploration, no physical facilities were available for the convalescent homes and recommended that definite action on this subject be deferred until such time as it would be possible to obtain trained personnel such as physi-

cians and nurses. The demands which have been made upon these two groups by the armed forces have made it necessary to reach this conclusion.

The subcommittee reported, however, that the Advisory Committee on the Care of Crippled Children should recognize that the problems and the frequency of cases occasioned by the cardiac cripple far transcend in importance that of poliomyelitis.

The subcommittee recommended that during the interval which of necessity must elapse that an educational campaign be conducted as extensively as possible in two fields, the first directed to physicians outlining the importance and the treatment of rheumatic heart disease, and the second a public educational program.

The committee adopted in general the suggested program on rheumatic heart outlined by the Metropolitan Life Insurance Company.

COMMITTEE ON GRIEVANCES

A. E. Rector, chairman, Louis Fauerbach, W. A. Ryan, A. J. Patek.

Charged with rather fundamental obligations to the medical profession of Wisconsin, the Committee on Grievances has been alert to the problems to be considered by it but has not felt the need for specific action during this last year. Other than the specific functions delegated by the provisions of the Constitution and By-laws of the Society, the committee has felt that it is now particularly concerned with activities during the ensuing year relative to two specific problems.

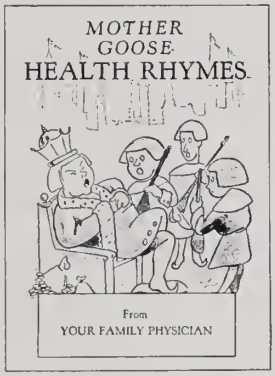
The first of these has to do with consideration of the plan developed in Minnesota relative to the review of expert testimony, particularly when substantial fields of scientific medicine are involved. It had been thought by your committee that this subject should be studied during 1942—1943 and that this session of the House of Delegates might be thoroughly advised with reference to the problem involved and the possibility of a satisfactory solution being offered. However, with the burdens thrown upon the Society as a result of the war effort and the obvious fact that its study could not be productive of results prior to adjournment of the 1943 legislative session, the committee recommended postponement of the subject for one year. It will be the purpose of your committee to examine the subject in detail during 1943–1944, however, and to report its final recommendations to the 1944 House of Delegates.

One other problem has been assumed by your committee and will be subject to discussion during the fall and early winter. This problem relates to the increasing practice on the part of certain insurance organizations to secure from patients having the benefit of hospitalization or surgical insurance coverage blanket permission to examine the records of attending physicians over such periods of time as the patients may have been under their care. It has been felt by many physicians that the privilege so sought by the insurance companies is not conducive to the best patient interest and that broad implications relating to public health were involved. It has been felt that this subject warrants careful consideration in anticipation of the possibility of working cooperatively with insurance representatives toward the development of more practical forms in this respect and ones which would not involve the possibility of complete study, examination, and even loss of physician-patient records.

The committee suggests to the House of Delegates that there is no need for specific action with reference to either of these problems at the present time, and, if agreeable to the House, this report will simply be offered as a progress report indicative of committee procedures.

COMMITTEE ON HEALTH AND PUBLIC INSTRUCTION

W. J. Egan, chairman, C. J. Newcomb, (in service), K. C. Kehl, alternate, G. W. Krahn



The work of the committee during the last year has been devoted to the continuance of the several health education mediums that were recently developed. Continued emphasis has been given to the use of the film strip "Health Achievements in Wisconsin" and to the distribution of the county fair exhibits and Mother Goose health rhymes.

Press Releases

Each daily and weekly Wisconsin newspaper receives a health news release once each week from the State Medical Society of Wisconsin. Carefully prepared topics have been available to the readers of Wisconsin newspapers that they may obtain accurate and reliable information on health. There are 325 weekly and 50 daily newspapers which receive the committee's weekly news releases.

Hygeia

Citizens of Wisconsin holding an office of public trust receive from the Society an annual subscription to *Hygeia*, the national health magazine published by the American Medical Association. These subscriptions have met with wide approval by those receiving it. Included among the recipients are state department heads, judges, presidents of normal schools, and others who in their official capacities are often confronted with health problems. This phase of the committee's work is annual in character and has been carried on for many years.

Exhibits

The Society was accorded an invitation to present a health exhibit at the State Fair to be held in Milwaukee, August 21 to 27, 1943. The assistance and cooperation of the Department of Exhibits of the American Medical Association was obtained in order that an effective well designed exhibit be secured.

Motion Pictures

The shortage of physicians has placed an increased burden upon those at home, and the pressure of demands upon their time has necessitated in some instances the substitution of their personal appearance before public groups with motion picture films. A wide selection of health subjects is contained in motion pictures that are available from the Bureau of Visual Instruction at the University of Wisconsin and from the State Board of Health. Films available from the latter source are contained in the Blue Book issue (January) of *The Wisconsin Medical Journal.* A complete catalog of films available on health topics is obtainable from the Bureau of Visual Instruction at the University. Any of the films can be secured on a minimum rental basis. Other films are also available from specialized public health education groups, such as the Women's Field Army and the Wisconsin Anti-Tuberculosis Association.

COMMITTEE ON MATERNAL AND CHILD WELFARE

A. C. Radloff, chairman, J. Gurney Taylor, J. J. Pink, J. W. Harris, Amy Louise Hunter, J. F. Wilkinson.

As a standing committee of the Society, this group is charged with the responsibility of scientific and procedural activities in the fields relating to the reduction of maternal and child deaths, vaccination and immunization, mental hygiene and child guidance, and similar matters relating directly to the title of the committee.

The committee has given a considerable portion of its time and effort during the current year to a consideration of the program developed under officials of the Children's Bureau of the United States Department of Labor, in which funds have been made available for obstetric and pediatric care for wives and children of men in service. A year ago preliminary efforts of the committee in the direction of cooperation with the State Board of Health in working out the program and with the Children's Bureau were reported, and during this last year these efforts have culminated in definite plans now generally available.

The first procedure was limited because of the funds available to Dane, Trempealeau, Jackson, Monroe, Juneau, La Crosse, and Vernon Counties, which embrace the chief military cantonment areas in this state. Supported by federal funds entirely, the plan provided free choice of physicians licensed to practice medicine and surgery, with fees established for obstetric care at $35 per case providing care which includes five or more prenatal examinations, care during labor, and a six-weeks' postpartum period. If less than the minimum services were provided, machinery was established for the adjustment of the fee. In cases in which only prenatal care was given, the physician was provided a fee of $3 for the initial visit, with subsequent visits reimbursed at the rate of $2 but not to exceed a total fee of $10.

In the trial plan, no initial fee was provided for operative care other than for cesarean section, in which the advice of a consultant was recommended and prior authorization was required except in acute emergencies. By arrangement with physicians, the fee for cesarean section varied between $90 and $100, with obstetric consultants being paid a fee of $10.

Somewhat similar procedures were followed in the instance of pediatric care for infants, with rates of $2 for hospital and office visits and $3 for home visits.

Subsequently, additional funds were made available by outright appropriation of the United States Congress. It is important to recognize that these funds are federal grants in their entirety without the state itself being required to match them either in whole or in part.

During May, 1942, it thus became necessary for the State Board of Health to submit to the Children's Bureau in Washington a proposal under which the plan would be broadened to a statewide basis for the ensuing fiscal year. This committee, with the State Board of Health, considered at some length the details submitted by the Children's Bureau in Washington. It noted particularly that under the proposal submitted at that time, the Children's Bureau indicated that the funds would be available for administration in accordance with the state plan, but the Bureau so circumscribed the state in its efforts to provide a plan wholly original and completely cognizant of the public health implications involved that the state was virtually forced to accept the federal plan with minor variations or nothing. Despite this situation, your committee met in numerous conferences in an effort to provide a plan at once practical and without features which would be inherently dangerous to the public health accomplishments of the State of Wisconsin. These efforts resulted in the announcement of a plan in June, 1943, copies of which were circulated to the entire medical profession through the cooperation of the Bureau of Maternal and Child Health of the State Board of Health and your committee.

The chief points of the plan which is now applicable provide obstetric fees of $40 for complete prenatal care, delivery care, and postpartum care, with the fees established for less complete care at the rate suggested under the preliminary experiment, the total of which, however, is not to exceed $15.

For delivery and postpartum care alone, the fee is set at $25. The fee for abdominal surgery provided under the cesarean section is set at not to exceed $40.

A distinct change was made in the provision for care of sick infants with the physician being allowed $3 for home visits and $2 for hospital and office visits, with a maximum of $18 being allowed for the first two weeks, thus giving the physician full discretion to apply the visits at the time they would do the patient the most good and not being restricted to a weekly basis unrealistic in its approach to the whole problem involved.

Your committee is advised by the State Board of Health that a considerable amount of activity is now under way in connection with the prosecution of these plans. It notes with particular interest the fact that the problem involved through a federal agency being so specific as to the details and mechanics of the plan received particular recognition at the Chicago sessions of the House of Delegates of the American Medical Association, with the result that a resolution was there introduced urging that any allocation for professional services should be given the wives directly, such patients then to secure the services of the physicians as those physicians, themselves, deemed proper. The fees for professional services would be decided by mutual agreement between the patients and the attending physicians. This resolution, presented by Dr. John H. Fitzgibbon of Oregon, was referred to the Committee on Public Relations, which reported to the executive session of the House on the ensuing afternoon. The reference committee report was adopted, which in effect approved the general purpose of the program but urged that the actual arrangements with respect to physician and patient be by mutual agreement with the wife and the physician of her choice.

It appears that various other state medical societies are cognizant of the implications involved in this program and are individually attempting to provide solutions that are realistic to the problems of public health. Just what may be accomplished in Wisconsin in this respect is uncertain, but your committee recommends to the House of Delegates its serious consideration of the problems involved and its recommendations, if any, to this committee as to the conduct of its future activities in this particular field.

COMMITTEE ON HOSPITAL RELATIONS

J. E. Habbe, chairman, W. H. Jaeschke, R. M. Waters, M. L. Jones, E. O. Gertenbach, Gorton Ritchie.

This committee was established as a standing committee on the basis of action taken in 1942 after activities along a somewhat similar line by a special committee of the House of Delegates had received considerable attention. As members will recall, the committee is charged with developing such procedures as will tend to strengthen those interests that are joint between the medical profession and the hospital institutions and to advise the Society from time to time of procedures that seem indicated in the various phases of the interrelationship between the medical profession and the hospitals.

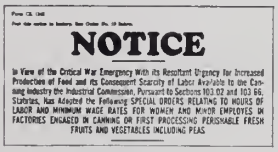
The committee has been particularly active during the course of this year in carrying into further development the section of the Annual Meeting program which provides for preparation of that portion particularly related to this field of activity. The program which will be presented on Wednesday, September 15, is one of particular pride to the members of this committee.

Your Committee on Hospital Relations does not believe that with the preparation, in cooperation with the Council on Scientific Work, of such programs as these its function to the Society is discharged. There are other matters of mutual concern to which the committee is directing its attention on the basis of long-term activities and planning. Of much immediate interest, of course, is the program which the committee urges upon the attention of the delegates and members of the Society with the request that they aid in the many ways possible in carrying the values of the program and the interest of the medical profession to those particularly concerned with the problems of hospital institutions.

COMMITTEE ON INDUSTRIAL HEALTH

Gunnar Gundersen, chairman, H. L. Greene, T. J. Howard, L. W. Hipke, ex officio

The war effort has catapulted the question of industrial health to the foreground. The emphasis which has been placed by President Roosevelt and the National Administration on the health of industrial, farm, and other workers has caused the attention of the entire nation to be focused on this subject. The acceleration which has been given to industrial health by the war effort has resulted in the telescoping of what was anticipated to be a three to five year program into a program of one or two years. The attitude of the Commander-in-Chief of our Army and Navy toward the importance of keeping our workers at work is best exemplified by his statement to the effect that the first objective of the country is the development of our armed forces and that the second is ". . . to man our war industries and farms with the workers needed to produce the arms and munitions and food required by ourselves and our fighting allies to win this war." Specifically, the President spoke of the farmer and his importance in our war program as follows: "Every farmer in the land must realize fully that his production is part of our war production, and that he is regarded by the nation as essential to victory."


Form CL 340
Post this notice in business, place of business, etc. of employer

NOTICE

In View of the Critical War Emergency With its Resultant Urgency for Increased Production of Food and its Consequent Scarcity of Labor Available to the Canning Industry the Industrial Commission, Pursuant to Sections 103.02 and 103.66 Statutes, Has Adopted the Following SPECIAL ORDERS RELATING TO HOURS OF LABOR AND MINIMUM WAGE RATES FOR WOMEN AND MINOR EMPLOYES IN FACTORIES ENGAGED IN CANNING OR FIRST PROCESSING PERISHABLE FRESH FRUITS AND VEGETABLES INCLUDING PEAS

Industrial Health Clinics

To assure Wisconsin workers an even greater service than that which had previously resulted in Wisconsin, the state enjoying the lowest worker absenteeism record in the United States, the Conference Committee on Open Panels, together with the Committee on Industrial Health, developed in cooperation with the Council on Scientific Work three industrial medical and surgical clinics, one on November 17, 1942, another on May 5, 1943, and a third on May 6, 1943.

These meetings were acclaimed by national authorities as being outstanding in bringing to Wisconsin physicians timely information on industrial health and were considered to be a distinct and direct contribution by Wisconsin physicians to the war effort.

Industrial Health Conferences

Employers, personnel directors, nurses, and others interested in employe health programs were so enthusiastic in their commendation of the meeting held in Milwaukee on November 17 that the Committee on Industrial Health, together with the Council on Scientific Work, began at once to plan for a program designed especially for lay persons interested in industrial health programs. An industrial health conference was held in connection with both the meeting held in Madison on May 5 and the one held in Appleton on May 6. Registrants at these meetings were enthusiastic in their comments concerning not only the special program for employers and others but also concerning the special evening program designed to be of joint interest to physicians and employers. There can be no question but that postgraduate medical education in the field of industrial health will continue to be one of the primary concerns of the Society.

Industrial Health Number, *The Wisconsin Medical Journal*

The entire scientific section of the February, 1943, issue of *The Wisconsin Medical Journal* was set aside for the presentation of industrial health subjects. This, combined with the special clinics, has resulted in the focusing of the attention of Wisconsin physicians upon the acuteness and the importance of this subject to individual physicians in rural areas and the metropolitan districts alike.

Hernia under the Workmen's Compensation Act

The committee had referred to it by the Council of the Society the question of compensability of hernia. At the request of the Council, the committee considered first in executive session and subsequently in conference with the director of the Workmen's Compensation Division of the Industrial Commission, Mr. Harry Nelson, the question of hernia as it relates to employment.

The committee concluded that the basis which was currently employed by the Commission in determining the compensability of hernia was in accord with scientific knowledge and need not at this time be altered. Upon the specific request of the Committee on Industrial Health, Mr. Harry A. Nelson has prepared for publication in *The Wisconsin Medical Journal* an article dealing with the attitude of the Commission on the question of hernia. This article is scheduled to appear in an early issue of *The Journal.* This question was initially referred to the Council by the Kenosha County Medical Society. The Committee on Industrial Health acknowledges its appreciation to the Kenosha County Medical Society and to the Council of the State Medical Society for the reference of this question and gives assurance that it will continue to study and appraise this problem.

Simplification of Report Forms

As a result of activities on a national level of a committee represented by the two insurance company associations, The American Mutual Alliance and the Association of Casualty and Surety Executives and a committee from the Council on Industrial Health of the American Medical Association, it was suggested that attention be given to possible simplification of reports required of physicians by compensation carriers and the Industrial Commission. The question of simplification of report forms on industrial accidents was referred to the Conference Committee on Open Panels which has the opportunity for frequent conferences with duly designated representatives of insurance company associations. The discussion of this subject in the report of the Conference Committee on Open Panels is encouraging and is in confirmation of the stated objectives of State Society committees to represent the physicians of Wisconsin.

American Medical Association Recommended Program for County Medical Societies

The Council on Industrial Health of the American Medical Association has prepared in brief outline form the essential features of a well organized and integrated program on Industrial Health that can be carried out by a county medical society.

As a direct result of the Industrial Health Conference held in connection with the Industrial Medical and Surgical Clinics presented on May 5 and 6 at Madison and Appleton, the Committee on Industrial Health actively cooperated with the Council on Industrial Health of the American Medical Association in initiating conferences with the Kenosha County Medical Society looking toward the establishment of an intensive industrial health program in that county which would receive the assistance of the Committee on Industrial Health of the State Medical Society and the Council on Industrial Health of the American Medical Association. Plans are going forward in Kenosha to inaugurate such a program.

Minor Employes

Shortage of manpower in Wisconsin has resulted in the granting of permission by the Industrial Commission for the employment of minors of 16 and 17, providing they have a physical examination and the examining physician certifies that such work will not endanger the health of the minor. The examination forms prepared last year by the Committee on Industrial Health for the Wisconsin Canners' Association were employed.

Recommendations

The Committee on Industrial Health recommends that during the ensuing year there be conducted several abbreviated industrial health programs similar in nature to those presented on May 5 and 6 which will incorporate both postgraduate medical education of physicians and public education of the objectives of medicine in industrial health.

COMMITTEE ON MEDICAL ECONOMICS AND VOLUNTARY SICKNESS INSURANCE

D. H. Witte, chairman, F. G. Anderson, L. D. Quigley, T. A. Leonard, Robert Krohn, A. C. Taylor

This committee, created by the 1942 House of Delegates, has carried forward the work formerly coming within the purview of a special committee of the House of Delegates, the Advisory Committee on Voluntary Sickness Insurance.

An opportunity has been given the committee to obtain extensive background and history through previous Committee reports and studies. Continuity of the Committee's work has been assured through the chairman and the secretary's office. The committee was privileged to obtain the advantage of the experience of others who have engaged in this highly technical field and has had the opportunity to discuss the question in person with representatives of the Americal Medical Association and of Michigan Medical Service.

While the above plan was submitted to the Farm Security Administration officials prior to the inauguration of this committee, the committee took occasion to review in detail the plan as submitted and recommended slight change.

Conferences held by the committee with officials of the Farm Security Administration resulted in their recommending the following changes:

(1) That a flat fee of $34 be established rather than a premium of $22 with a withholding feature of $11 and a trustee allowance of $1 per year per family as set forth in the plan submitted by the Special Committee on Voluntary Sickness Insurance.

(2) That a representative of the Farm Security Administration be made an ex officio member of the conference committee composed of representatives of the county medical society and representatives of the subscribers.

(3) Permission granted for the review by a representative of the Farm Security Administration of the financial status of any applicant before a decision was reached by the county medical society to reject any applicants on the basis of financial status.

(4) The original contract submitted to the Farm Security Administration provided for 90 per cent participation of the eligible borrower families. This the Farm Security Administration stated was too high. The committee acceded to their wish and lowered this requirement from 90 per cent to 75 per cent.

(5) The original plan provided for automatic termination at the end of twelve months. The Farm Security Administration wished to modify this to provide that a means be established for the renewal of the agreement.

The Special Committee on Voluntary Sickness Insurance (1941) recommended that the procedure to be followed in inaugurating new experimentation would be for initial consideration by the Committee on Voluntary Sickness Insurance and, if approved by them, their recommendation to this effect should be submitted to the Council. This procedure was followed in connection with the plan submitted to the Farm Security Administration.

A list of five communities located for the most part in the northern part of the state was submitted to the committee by the Farm Security Administration as communities in which it would like to see the trial plan placed in operation. Accordingly, the committee submitted first to the officers of one of the county medical societies and subsequently to its entire membership the plan as arranged by the Committee on Medical Economics and Voluntary Sickness Insurance. As this report is written, further conference with the county medical society is scheduled, and a further progress report will be presented to the House of Delegates when in session.

Other activities closely allied with the Farm Security Administration coming to the attention of

Farm Security Administration

Salient points of Farm Security Administration prepaid medical care plan.

This plan will be limited to borrowers of the Farm Security Administration. These borrowers will be afforded free choice of physician from among all members of the county medical society indicating that they wish to participate. The services afforded the subscribers will be the professional services generally rendered by physicians in that community. It provides complete medical care unlimited as to extent. Each subscriber family is required to pay a premium of $34 per year in advance. Seventy-five per cent of all eligible subscribers must join before the plan becomes operative. Recognizing that borrowers of Farm Security Administration are neither self sustaining nor indigent, a discount of 25 per cent from normal fees will be afforded the plan. A committee from the county medical society will audit and order payment on all approved statements.

the commitee are the subsidy plans for prepaid medical, dental, hospital, and nursing care now being subjected to experimentation in other states. Under the provisions of this plan, any farm family may subscribe to the program by remitting to the special agency created 6 per cent of its cash income. The Federal Government, through the Interbureau Coordinating Committee on Post-War Programs of the Department of Agriculture, will remit the difference between the amount paid by the subscriber and from $50 to $57 which has been determined by this federal agency as the premium needed.

Migratory Workers

During the last year, upwards of 1,000 Jamaican migratory workers assisted in harvesting crops in Wisconsin. Under the contract which was entered into by the United States with the British Government, these workers were assured their medical care. A federal agency, understood to be the War Food Administration, advanced to a private corporation organized for this specific purpose funds with which to meet costs incurred in rendering medical care to these migratory workers. Payment was made to physicians on the basis of statements rendered.

Surgical Indemnity Coverage

Under the terms of this plan, employes having a common employer would be eligible to obtain a policy which would provide the worker and his family with complete surgical coverage regardless of the amount or the extent. Physicians participating under the plan would provide surgical care in the hospital, office, or home. Premiums tentatively established are: Single persons 60c, Husband and Wife $1.35, and Family $2.40. The premiums are to be collected by representatives of the employes' association, either by direct collection or by payroll deduction. Eligibility to the plan would be determined on a group selection basis. A predetermined percentage of employes would be required. Premiums collected by the employes' association are to be remitted to the county medical society and distributed to physicians by the society. A special committee from the county medical society would review and audit all statements submitted.

As reported by the Committee on Voluntary Sickness Insurance to the 1942 House of Delegates, a request had been received by a county medical society in the eastern part of the state from an employes' association for a prepaid medical care plan providing surgical coverage. A detailed plan was prepared particularly for the careful consideration of a committee from the county medical society. This plan was reviewed in detail in joint session of the Committee on Medical Economics and Voluntary Sickness Insurance and the special committee in the county medical society. At the suggestion of the special committee from the county medical society, a digest of the plan evolved at this joint session was circulated to each member of the county medical society with the assurance that every assistance would be given the society should it desire to take further steps in placing the plan in operation.

The experience to date appears to indicate that at the present time the only type of prepaid medical care plan which is meeting with any marked degree of public favor is that type of coverage which is limited in extent to indemnifying the subscriber for surgical care. The premiums are relatively nominal and a minimum of sales resistance is encountered.

As indicated to the House of Delegates in 1942, the definite trend in prepaid medical care plans is not to encourage the procurement of complete coverage policies, but to urge the sale of the limited benefit policies.

Medical Service Plan Council

An organization has been developed embracing in its membership those state and county medical societies that have in operation a plan of voluntary sickness insurance. The intent and purpose of this Council is to bring together and correlate the knowledge and experience of each of the plans and to act as a clearing house for the joint benefit of all in the dissemination of information. It is anticipated that the future efforts of this organization will be to establish actuarial information on the experience of these plans.

Principles

In the course of its deliberations and conferences, the committee has had ever before it the principles and guiding recommendations that have been developed by earlier committees of the Society and adopted by the House of Delegates. The report of the Special Committee to Study the Distribution of Health Service and Sickness Care in Wisconsin on voluntary sickness insurance, as amended by later actions of the House, is considered as "the book" by the committee. The House of Delegates, when it authorized experimentation in voluntary sickness insurance by the adoption in 1938 of the recommendations of that committee, established well considered and concise principles. These principles are set forth in detail in a supplement to the October issue of *The Wisconsin Medical Journal.* In markedly condensed form, these principles provide that patients shall not receive a deliberately cheapened service under a plan for prepaid medical care; that patients are to be assured free choice of physician; that profit must not be the motivating force behind experimentation; that there shall be no duplication of experimentation that has already been proven to be unsound; that experimentation should be limited in extent of its application until its usefulness has been demonstrated; that all agreements with subscribers in experimental efforts should be unmistakably clear in their terms; that no profit should accrue to any promoter of any joint plan of the profession and the public; that the membership

of the county medical society should stand as guarantor of the service to the subscribers; that if any of the experiments should prove to be of merit, its scope should be expanded and extended.

At subsequent sessions of the House of Delegates further principles were enunciated and early ones reconfirmed. In 1940, the House adopted the recommendation of the committee that the sales solicitation of subscribers and accounting procedures should not be delegated to any agency other than the Society. A further recommendation approved at this session of the House of Delegates provided that only the State Medical Society should engage in experimentation and that the Council of the Society and the Committee on Voluntary Sickness Insurance should jointly approve all future experimental efforts.

Recommendations

1. The committee recommends continued experimentation in accordance with previously adopted policies and principles of the House of Delegates.
2. Further studies should be conducted by this committee of plans established by organized medicine for the prepayment of medical care.

COMMITTEE ON MENTAL HYGIENE AND INSTITUTIONAL CARE

H. H. Christofferson, chairman, B. J. Hughes, S. K. Pollack.

In accordance with previous recommendations by this committee which were approved by the 1942 House of Delegates, the committee has visited this year a total of six county institutions for the care of the mentally ill. The committee is impressed as a result of its visits with the inertia in the provision of medical care for those who are committed to these institutions. Those who are patients at the county institutions are presumed to be evidencing stationary mental manifestations, and it is assumed that an opinion has already been rendered that further psychiatric therapy would not likely alleviate or improve their mental condition. In some instances, however, there are direct commitments from the county judge to the institution, and these cases have not been studied and treated at the two state hospitals for the acute mentally ill.

For the most part, medical care now provided patients of county institutions is limited to the treatment of apparent and obvious conditions and those cases which because of their acute nature demand attention. There are a limited few institutions in the state that do provide a periodic physical examination of those who have been committed to their care. It is the exception rather than the rule that patients are afforded that basic medical service, a thorough physical examination. Those who have command of their faculties and are not institutionalized can on their own volition obtain an examination and medical care as the need arises. These patients, however, are not capable of determining whether they need an examination or treatment.

The extent and character of medical care afforded patients at many county institutions can be exemplified in part by the patient medical case histories and records which are maintained. The institution is required to maintain what has come to be known by the superintendents as "the doctor book." This is a chronologic record of the care that has been given to the patients in the institution, and while it is maintained to a degree sufficient to meet the requirement, the extent of the record is limited to fulfilling a "lip service."

Previous investigations made by the subcommittee on Health and Disability of the Citizens' Committee on Public Welfare and earlier studies made by this committee have indicated that the care which is now being given these patients leaves much to be desired. The visits of this committee during the current year, together with its study of earlier investigations, leaves them with the inevitable conclusion that there is an absence of a planned corrective health program in the institutions. The minimum requirements of a visit to the institution by a physician once each week is generally met, but there is a virtual absence of nursing and hospital facilities.

The committee has considered recommending to the Committee on Public Policy that this lack of care in the county institutions be rectified through legislative action. The committee's current opinion, however, is that a more effective approach and one which would have a more lasting effect and, in fact, accomplish greater results would be an educational program of a cooperative character with the asylum superintendents and their trustees. The immediate direction of this cooperative effort would be twofold: first, an effort to secure a standardization and modernization of medical records or case histories at the county asylums and, second, the establishment of possible minimum standards of medical care at county institutions.

A Committee of the County Asylum Superintendents' Association is currently at work to formulate its conception of what should be initially established as minimum standards on both the question of records and medical care in county institutions.

Asylum Physicians

The committee feels that a planned effort should be made to develop an esprit de corps among the asylum physicians to impress upon them the importance of their work and the great accomplishments that could be made by diligent application. The development of this spirit among asylum physicians can be fostered initially through a series of special letters directed to them by the Committee on Mental Hygiene and Institutional Care and a continuance of the special round-table luncheons for asylum physicians and superintendents at the time of the Annual Meeting.

Recommendations

1. The committee has taken occasion to review that portion of the report of the subcommittee on health and disability of the Governor's Citizens' Committee on Public Welfare which related to county institutions. It is recommended that a recirculization of this report be made to members of the Board of the Department of Public Welfare and to asylum physicians throughout the state.

2. Earlier reports of this committee, as well as the subcommittee on health and disability, have devoted attention to the inadequacy of the professional staffs at the state hospitals for care and treatment of the acute insane. This committee is convinced that the flow of patients through these two hospitals could be markedly increased and a larger number of patients studied and treated if the professional staff personnel at the two hospitals were increased.

The committee recommends that the minimum standards for mental hospitals as adopted by the American Psychiatric Association relating to staff requirements be met as nearly as possible consistent with current conditions.

3. Provision is now made for the diagnosis and treatment of the acute mentally ill and for the care of the chronic insane. In practice, however, the chronically insane who are disturbed or violent are not wanted by the county institutions and are referred back to the two hospitals established for the care and treatment of acute cases. The committee recommends that provision be made for the establishment of a means to care for those suffering from a mental illness that has been determined to be not susceptible to improvement through further medical care but who are disturbed.

4. In anticipation of a demand for trained nursing personnel which will arise as a result of educational work among county asylum physicians and superintendents, the committee recommends that provision be made for the special training of nurses for psychiatric work. Greater facilities should be perfected in the state for this training. The committee recommends that this specific question be considered by the Committee on Nursing Problems and, if it is their considered judgment that these special facilities should be established, that they employ whichever means seems most desirable to effect the intent of this recommendation.

5. Excellent facilities are available for postgraduate medical education in the care of the mentally ill at Winnebago State Hospital and at Mendota State Hospital. The committee recommends that each county asylum physician devote a minimum of a week at one of these two state hospitals and that the trustees of the county asylum to which he is attached should make budgetary provision for such attendance.

6. Appropriate facilities for the care, examination and treatment of the mentally ill should be provided at county institutions and appropriate case records should be provided for each patient. At county institutions there rarely exists an examining and treatment room, and, as previously mentioned, little attention is given to the maintenance of an accurate case history. Each institution should have facilities for the care of those who are assigned to them but who become acutely ill from other means than a mental derangement.

7. It is recommended that physicians attending county hospitals for the mentally ill make a periodic physical examination of all patients.

8. A concerted effort should be made by this committee and by the Department of Public Welfare to provide occupational and recreational facilities for patients at county mental hospitals. Little attention is given to occupying the time of these patients when not at work.

9. In order that an increased staff might be attracted to our state institutions for the care of the mentally ill, as well as to our county institutions, salary scales at the two state hospitals, the two colonies, and the hospital for the criminal insane should be increased.

10. After an analysis of existing conditions, the committee urges that increased emphasis be placed on environmental investigations of the social problems presenting themselves in the patient's home, looking toward the rehabilitation of those discharged from institutions for the mentally ill. These investigations would also emphasize the prevention of recurrence and of repeated follow-up to the end that a complete recovery might be had of those discharged from institutions.

11. The committee recommends that separate facilities be established for the care of the criminally insane women.

12. On previous occasions this committee has recommended that separate receiving facilities be established at the Mendota State Hospital. The committee reports that such facilities have not been established and recommends that this be called to the attention of the proper state department. It is also recommended that the receiving facilities at the Winnebago State Hospital be expanded and improved.

13. The committee re-emphasizes the need for improved means of transporting the mentally sick to institutions. The medieval methods used is a reflection on the citizens of the state. A complete disregard in many instances is given to the individual problems that are presented, and the patient is remanded to the care of the sheriff to be transported in such a way as he may feel is indicated. The committee recommends that the physician-adviser to the county judge should direct the manner in which patients should be transported, namely, whether by ambulance, car, or train or whether they should be remanded to the care of the sheriff.

14. The committee recommends that efforts now be made to establish a means for training ward attendants at the institutions for the care of the mentally ill. Initially, at least, the extent of the course of training can be limited in its extent and the time consumed.

15. The committee recommends that facilities be established for the care, supervision, and rehabilitation of the juvenile insane and of the epileptic.

The committee's investigations during the current year have indicated the direction of its future efforts, and the two recommendations that follow establish in part the course to be followed by the committee during the ensuing year should these two recommendations be approved by the House of Delegates.

16. A thorough review and study should be made by the committee of the laws and regulations pertaining to the commitment and care of the mentally ill. Following their studies, recommendations should be formulated and any recommendations for modification or change in statutory or regulatory provision should be forwarded to the Committee on Public Policy of the Society.

17. The committee recommends that authorization be given it for a survey of at least one county institution for the care of the mentally ill to make, as a demonstration feature, a thorough physical examination of all in the institution and that a case history be made of all those in such an institution or institutions. The personnel for the conduct of such an examination would be recruited by the Committee on Mental Hygiene and Institutional Care and the examination of the patients be made without charge to the county which indicated its desire to have such an examination made.

A combined meeting of the Committee on Mental Hygiene and Institutional Care and the Committee from the Association of Asylum Superintendents is scheduled to be held early this fall. The purpose of this combined meeting is to formulate minimum standards of medical care in county mental institutions to which both this committee and the Committee from the Association of Asylum Superintendents can subscribe.

COUNCIL ON SCIENTIFIC WORK

E. R. Schmidt, chairman, F. D. Murphy, C. J. Smiles, K. H. Doege, W. S. Middleton, ex officio, E. J. Carey, ex officio, C. D. Neidhold.

The efforts of the Council on Scientific Work during the past year were redoubled to avoid any possible lapse in postgraduate medical education in Wisconsin during this wartime period. With scientific research being given an added impetus in order to cope with medical and surgical problems aggravated or induced by war conditions, it is imperative that this widened scope of research be brought to Wisconsin physicians and applied to their day by day practice.

Scientific Program

By custom, the Council on Scientific Work delegates from among its membership one whose special duties during the year shall be the arrangement and perfection of a scientific program under the general direction and supervision of the entire Council. For the One Hundred Second Anniversary program, the Council selected Dr. F. D. Murphy of Milwaukee to carry out the Council's concept of the nature of the program.

Letters of appreciation had barely reached the desks of physicians who had participated in last year's Annual Meeting when preparations were begun to formulate the programs for this year and to obtain early commitments from speakers to appear on the program.

In the interests of correlation and uniformity, Dr. Murphy invited the section chairmen to meet with the Council on Scientific Work and map out the general nature of the program and asked that each prepare and submit to the Council a program for his section.

A studied effort was made by Dr. Murphy and the Council to attune this program to the wartime needs of Wisconsin physicians.

Section on Hospital Relations

The Committee on Hospital Relations of the Society requested and secured a program designed to be of immediate and vital interest to chiefs of staff, hospital superintendents, chairmen of hospital boards, and others connected with administrative problems in hospitals.

Scientific Exhibits

The motivating thought in the establishment of the Council on Scientific Work was to formulate a committee of the Society that would have charge of the professional educational efforts. The continuity and correlation of effort is effectively demonstrated by the direct correlation of the program and the scientific exhibits at this meeting. The Council requested Dr. C. D. Neidhold of Appleton to arrange the exhibits. By virtue of knowledge of early plans for the meeting, it was possible for Dr. Neidhold to obtain exhibits that would augment and amplify topics presented on the program. An example of this correlation is the applied anatomy exhibit on the gastrointestinal tract and the liver, in which physicians may complete their studies initiated in the symposia on these subjects. Likewise, there will be found an exhibit on tropical diseases which amplifies the presentation on the general sessions program and the round-table luncheon on this subject.

The popularity of the exhibits is demonstrated by the large number of physicians who view and study them. The exhibits have won for themselves a prominent place in the field of postgraduate medical education, and the Council on Scientific Work acknowledges their merit by the emphasis that is accorded them.

Industrial Health Clinics

The presentation of three widely attended industrial health clinics is demonstrative of intercommittee cooperation. The Conference Committee on Open Panels first suggested the development and presentation of industrial health clinics. The question was considered by the Committee on Industrial Health, which in turn referred the actual presentation of the subject to the Council on Scientific Work. During the last year, an industrial health clinic was held in Milwaukee on November 17, 1942, in Madison on May 5, 1943, and in Appleton on May 6, 1943. At each of these three meetings there was presented in addition to the full-day scientific program, an elaborate array of scientific exhibits.

Employers, personnel directors, plant superintendents, industrial nurses, and insurance companies received so enthusiastically the initial meeting which was presented in Milwaukee on November 17 that a special program was prepared for the lay public for the afternoon at both the Madison and Appleton meetings. The information which was brought to this group was enthusiastically received, and the health of Wisconsin workers was benefited.

Gas Warfare

During the last year, great emphasis has been placed by the Office of Civilian Defense on the subject of gas warfare. Dr. John S. Coulter, Regional Medical Officer of the Office of Civilian Defense, has urged that there be conducted in Wisconsin the standard six-hour course on the medical aspects of chemical warfare. The Council on Scientific Work, in cooperation with the Committee on War Participation and the Office of Civilian Defense, is currently at work perfecting details for the conduct of these courses in those areas that are designated by the Army and the Office of Civilian Defense as target areas. Under the direction of Dr. J. S. Supernaw, State Chief of Emergency Medical Service, Doctors E. L. Belknap and Anthony Curreri, and the Council on Scientific Work, physicians in these areas will be afforded an opportunity to receive special training in the treatment of this type of civilian casualty.

County Medical Society Programs

The departure of many Wisconsin physicians to military duty resulted in county medical societies experiencing difficulty in obtaining speakers for their monthly meetings. To assist partially in filling the gap, the Council on Scientific Work directed that there be prepared several loan packets containing catalogs of scientific motion pictures. These catalogs have been made available to secretaries and presidents of county medical societies, and repeated announcement of this added service has been presented in the pages of *The Wisconsin Medical Journal.*

The Wisconsin Medical Journal

The By-Laws of the State Medical Society provide that "it (the Council on Scientific Work) shall also be in charge of the affairs of *The Journal.*" The active direction of *The Wisconsin Medical Journal* is under the immediate supervision of the medical editor, Dr. Karl Doege of Marshfield. Questions of policy and general direction are given to the medical editor by the Council on Scientific Work. The Council, in critically appraising *The Journal* in comparison with similar scientific publications of other state societies, has reached the conclusion that *The Wisconsin Medical Journal* is one of the leading, if not the leading, medical journal in its class.

COMMITTEE ON TUBERCULOSIS AND CHEST DISEASES

L. O. Simenstad, chairman, G. D. Reay, A. A. Pleyte.

The committee's activity during the last year has been a furtherance of the program determined in 1942.

Cooperative effort has been given the technical advice program for physicians developed by the Wisconsin Anti-Tuberculosis Association for the making of chest roentgenograms. Announcements of the availability of this service to the profession were made through the pages of *The Wisconsin Medical Journal* and by bulletin to the presidents and secretaries of county medical societies. Under this program, physicians would have available to them, on request, the advice of specially trained members of the staff of the Wisconsin Anti-Tuberculosis Association in the methods to be employed in obtaining a roentgenogram of the detail and character necessary in making an accurate diagnosis of tuberculosis.

Through the efforts of the committee, the Council on Scientific Work has allocated exhibit space at the One Hundred Second Anniversary Meeting of the Society to the Wisconsin Anti-Tuberculosis Association that further educational work might be continued in this field.

The customary annual message on tuberculosis to members of the Society was contained in the booklet "Tuberculosis Summed Up," which was a report to Wisconsin physicians on the reported cases of tuberculosis in which deaths occurred and the program which is needed in Wisconsin further to control tuberculosis. This need was set forth as follows:

(1) More early discovery work
(2) Prompt reporting of active cases
(3) Follow-through on all tuberculosis rejectees
(4) Isolation of open, active cases
(5) Prompt treatment
(6) Rehabilitation

4. REPORTS OF COMMITTEES OF HOUSE OF DELEGATES

COMMITTEE TO STUDY PROBLEMS RELATING TO THE MEDICAL PRACTICE ACT

R. G. Arveson, chairman, E. J. Carey, W. S. Middleton (in service), C. A. Dawson, C. D. Neidhold, H. M. Coon (alternate member)

As the House of Delegates and the Society are aware, this committee was organized as the result of action taken at the 1941 Annual Meeting of this Society. Following an address by President Gunnar Gundersen, the House of Delegates approved a committee to be appointed for the purpose of reappraising all aspects of the Medical Practice Act as well as the method for determining the composition of the State Board of Medical Examiners itself.

Aided by an immense volume of material assembled through the secretary's office, this committee entered into detailed study. It considered and reported to the House of Delegates in 1942 the various problems concerning the Medical Practice Act which it felt were outstanding, but stated at that time that it felt constrained to limit its report to the antiquated procedures for the appointment of members of the administrative board and the need of annual registration of physicians.

The committee's report was accepted by the House of Delegates, and the committee continued as a cooperative agency with the Committee on Public Policy for the framing of legislation to be introduced at the 1943 session of the Wisconsin Legislature. Details with reference to that legislation are contained in the report of the Committee on Public Policy. Suffice it to say that the Committee to Study Problems Relating to the Medical Practice Act participated wholeheartedly and vigorously in consideration of the subject and feels that in the enactment of the annual registration law in Wisconsin the medical profession and others have taken a significant step in the furtherance of public health objectives.

The committee believes it should be continued with the specific charge from year to year that it may be available to serve in matters relating to administration of the annual registration law, as well as with reference to the topics concerning the Medical Practice Act which are presented from time to time. Committee members are cognizant that there is a continued change for the better in both the administration and the basic considerations given the Medical Practice Act but feels there is much to be done in the further promotion of the public health aspects of this law.

If the House of Delegates chooses to accept the report of this committee, that action will be sufficient to sustain the committee's composition until such time as the House acts to the contrary.

COMMITTEE ON NURSING PROBLEMS

W. A. Munn, chairman, H. M. Stang, Burton Clark, Jr., F. A. Stratton

The Committee on Nursing Problems, a special committee of the House of Delegates, feels that it has accomplished much of its original purpose since its creation several years ago. At the 1941 session of the House of Delegates it was urged that this committee be appointed to examine into the apparent difficulties relating to the shortage of nurses and to propose ways and means of alleviating the acute public health problem.

After detailed and prolonged investigation, including numerous conferences and field trips, the committee reached the conclusion that without action on a national scale it would be impractical for Wisconsin to undertake any substantial revision of the nursing practice act and so reported to the House in 1942. As a result of the report at that time, the House of Delegates approved this committee's framing, in cooperation with the delegates of this Society to the American Medical Association, a resolution calling upon that Association to engage in cooperative studies in an effort to present ways and means for the solution of this problem. The committee notes with regret that the resolution so framed and presented was rejected by the House of Delegates of the American Medical Association and suggests that the Society's delegates to the American Medical Association may find it advisable to resubmit the resolution next year.

However, following the 1942 session of the House of Delegates of the State Medical Society, your committee continued its activities in the field of examining possible procedures for the establishment of so-called licensed or trained attendants in Wisconsin. As a result of the activities of your committee and with the cooperation of representative groups consisting of the Wisconsin Hospital Association, the Wisconsin Conference of Catholic Hospitals Association, the Wisconsin State Nurses Association, and through the Committee on Public Policy of this Society, the Society itself stood sponsor of bill 611, A. in the legislature calling for permissive legislation to enable the licensing of trained or licensed attendants as subsidiary workers in the health care of the ill of this state. The bill passed both houses of the legislature without any substantial opposition and was signed by the Governor of the State of Wisconsin.

As a result of its work in this field, the Committee on Nursing Problems has the assurance of the Committee on Nursing Education and the Bureau of Nursing Education of the State Board of Health that further cooperation will be shown in the development of realistic and practical rules and regulations in the field pertaining to establishment of schools for licensed or trained attendants.

It is felt that this legislation is the direct result of the efforts of the House of Delegates acting

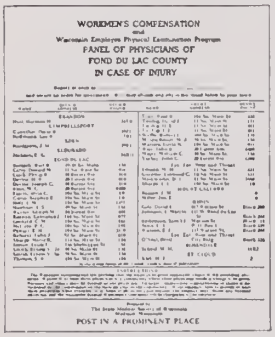
through this committee and that it will prove a significant step in the future of the public health of the people of this state.

It is, therefore, suggested by your committee that the House of Delegates, by specific action, authorize the continuance of the committee as a special committee of the House, empowered to act through the Council and the Committee on Public Policy of the State Medical Society of Wisconsin as a liaison agency between the medical profession and nursing interests in Wisconsin.

5. REPORTS OF COMMITTEES OF THE COUNCIL

CONFERENCE COMMITTEE ON OPEN PANELS

R. M. Kurten, J. H. Karsten, Mr. E. E. Langworthy, Mr. C. W. Kroening


WORKMEN'S COMPENSATION
and
Wisconsin Employers Physical Examination Program
PANEL OF PHYSICIANS OF
FOND DU LAC COUNTY
IN CASE OF INJURY

POST IN A PROMINENT PLACE

With each distribution of the Workmen's Compensation panels of physicians to over 50,000 Wisconsin employers, the Conference Committee on Open Panels has witnessed more and more universal acceptance of the panels by Wisconsin employers. The Open Panel Agreement has afforded Wisconsin employes a much wider choice of physicians than is accorded employes elsewhere. Evidence that the panels are being posted by employers is contained in the increased demand which is made upon the Society for additional copies for posting in warehouses, branch offices and other locations under the employers' jurisdiction.

Insurance company members of the conference committee state that larger numbers of physicians are treating compensation cases now than was the case prior to the inauguration of the Open Panel Agreement.

The conference committee directed that in the preparation of the panels members of the Society who have entered the armed forces of the United States and who were previously listed be continued and that their military service be denoted by a small flag preceding their names. In this manner the physician will not lose his identity with the community, and his return and the resumption of his practice will thereby be aided.

Simplification of Report Forms

The Committee on Industrial Health early during the last year received the suggestion that a study be made of the reports now requested of physicians by insurance carriers and the Wisconsin Industrial Commission. The insurance companies writing essentially all the compensation in Wisconsin are members of national organizations of stock and mutual companies. A Joint Medical Committee of these two national associations and a subcommittee of the Council on Industrial Health of the American Medical Association have each considered this problem. Composed as it is of representatives of the insurance company associations and the Society, the question was referred to this committee by the Committee on Industrial Health.

The committee investigated the existing report forms and particularly those that had met with wide favor among practicing physicians. This question was considered at a meeting of the Conference Committee on Open Panels, and all members readily agreed that marked simplification could be effected and that undoubtedly efforts could be made to have a standardization of report forms requested by insurance carriers. The committee also suggested that, perhaps, simplification might be effected in the forms now used by the Industrial Commission. It was the recommendation of the committee that a meeting be called specifically to consider the simplification of insurance forms and that to this meeting should be invited physicians and others who might make a contribution to the deliberations. The meeting of the committee for this purpose is scheduled for October.

Complaints

Under the provisions of the Open Panel Agreement, physicians listed on the Society's panels are required to forward to the commission and the insurance carriers necessary reports. In the light of the great number of compensation cases arising during the year, the number which are referred to the Conference Committee on Open Panels by either insurance companies or the Commission is relatively few. During the last year, however, it was found necessary by the committee, to recommend to the Council that several physicians be refused listing on the basis of failure to make reports. The Council of the State Medical Society concurred in this recommendation. The committee looks forward to a still further reduction of this problem through the suggested simplication of report forms.

Treatment of Compensation Cases

The committee recognized that associated with the extension of choice of physician by the employe there evolved upon the profession the responsibility of assuring the employe that physicians would be competent to treat the conditions presented. It was apparent to the committee that part of this problem would be met by more thoroughly training physicians in those conditions most likely to be encountered in the treatment of compensation cases. The Conference Committee on Open Panels recommended to the Council on Scientific Work and the Committee on Industrial Health that there be conducted postgraduate courses emphasizing this phase

of medicine, and demonstrating to employers and others the advantage of a well planned health program in industry. Three such courses were held during the last year and are described in detail in other committee reports. It is anticipated that in the future additional courses designed especially for county medical society meetings will be held.

COMMITTEE ON WAR PARTICIPATION

Ex officio members: President, President-elect, Chairman of the Council, Secretary of the Society, and State Consultant of Procurement and Assignment Service

Subcommittee on Procurement and Assignment Service

E. J. Carey, Milwaukee, chairman
H. M. Coon, Madison
J. W. Prentice, Ashland
F. X. Pomainville, Wisconsin Rapids
P. R. Minahan, Green Bay

Subcommittee on Replacements

R. W. Blumenthal, Milwaukee, chairman
S. D. Beebe, Sparta
E. C. Cary, Reedsville
H. A. Sincock, Superior
A. A. Cantwell, Shawano

Subcommittee on Civilian Defense

J. S. Supernaw, Madison, chairman
R. W. Blumenthal, Milwaukee
V. E. Ekblad, Superior
T. C. Hemmingsen, Racine
A. G. Koehler, Oshkosh
F. G. Anderson, Eau Claire
C. N. Neupert, Madison

The Committee on War Participation was developed as the result of action by the Council of the State Medical Society of Wisconsin following the annual meeting of the American Medical Association in Atlantic City in June, 1942, at which time the national association discharged its Military Preparedness Committee and created a new Committee on War Participation. The State Medical Society, through its Council, felt that similar action for purposes of convenience was indicated and would better develop on a state level the activities of the medical profession during the national emergency. The new committee was organized and its functions outlined by the Council on July 12, 1942.

This group has organized its activities and contributed much in a cooperative manner toward the accomplishment of objectives of medicine during these trying times. Functioning in complete harmony with the official agency of the Procurement and Assignment Service throughout the state, the Committee on War Participation is representatively staffed and numbers among its members virtually all of those who hold official appointments on behalf of the medical profession in these three specific fields.

Rather than submit a lengthy report which could of itself merely recapitulate the accomplishments generally recognized and appreciated by the medical profession, the Committee on War Participation desires, rather, to outline the general principles which have guided its activities in the fundamental results of applying those principles to current problems.

Procurement and Assignment

It was early recognized in the field of the Procurement and Assignment Service that the development of a modern war machine would be comprehensive and be of such strength and in such detail that comparison of the Army of 1917 and 1918 with that anticipated for the current World War could indicate nothing more than a symptom of the problem with which the medical profession and the people as a whole were about to be confronted. Early in the history of the Procurement and Assignment Service, through the state office of the state chairman as well as through the office of the State Medical Society, every effort was made to advise physicians of the tremendous implications that lay in assuring to the armed forces, as well as to the people, the complete cooperation of the medical profession, both on a state and national level.

Inevitably, some provincialism became one of the obstacles confronting the Procurement and Assignment Service. Inevitably, too, uncertainty became something of a contagion and, as it might be expressed by single individuals, it tended to become the state of mind of numerous individuals within the medical profession. Yet, it is to the credit of the medical profession in Wisconsin that, inspired only by the highest motives, it has produced the cooperation which was assured by the action of the American Medical Association in seeking the creation of the Procurement and Assignment Service and which has long been the pride of the profession in all times of national need.

Thousands of physicians have served generously and to an extent that could emanate only from a professional group selfless in its ideals in the administration and assistance of the Selective Service. Hundreds of physicians have participated in a cause of equal import in assisting in the program of Civilian Defense and in rendering their cooperative efforts to the ultimate aim of the Procurement and Assignment Service.

Civilian Defense, itself, posed a difficult but recognized problem to the medical profession of Wisconsin. National authorities had sought its establishment patterned on those programs which had proved most valuable and successful in other countries which are now our allies. Of fundamental importance at the outset and throughout the entire program of Civilian Defense has been the participation of the medical profession and its preparedness in advance of any catastrophe Unlike some phases of

Civilian Defense, it was faced with the responsibility of selling the intangible needs of the government for the complete cooperation of the entire populace; the medical profession was also confronted with the problem of being well prepared for any conceivable incident.

Under the able leadership of the state chief of Emergency Medical Service and with the complete cooperation of all authorities in local areas in this field, the medical profession in Wisconsin, through its State Medical Society, through its many participants in the program, and through its various assistant state chiefs, has developed a program of particular note nationally and of real pride locally. The Committee on War Participation, as an entire committee, can do no less at this time than to commend in the most forceful language at its command the medical profession of Wisconsin for its wholehearted interest and its generous and understanding support of activities in this field.

Replacements

The Subcommittee on Replacements of this committee has undertaken an unusual and most valuable function in the whole program. Its cooperation with the Procurement and Assignment Service, its study and assistance in fields in areas asserted to be in need of medical care, its cooperation with Wisconsin physicians and physicians of other states who desire to locate or relocate in Wisconsin, its complete understanding of the whole problem, and its available records have been of invaluable assistance to communities, to those interested in the public health level, to those interested in the institutional level, and to the individual physicians throughout the state. As a result of its efforts and the cooperation it has received from other sources, the Subcommittee on Replacements has become the recognized agency for assisting in this most valuable activity.

Not alone that, but the Subcommittee on Replacements has had the vision and the ability to foresee that its activities would become of increasing importance as the duties of war carried this nation to further depths of strain and as the days of peace bring the problems of resettling a medical profession to the needs of the health of the people. The subcommittee has not been unaware of but has considered and studied the problem and has at all times undertaken those procedures which in the days of decisive victory to come will assure a continuance of the high quality of medical care within the State of Wisconsin.

The Committee on War Participation files this report as its own and in behalf of its three subcommittees, which themselves are unable to speak with the frankness and in the manner demanded. It offers to the medical profession of Wisconsin its assistance, as well as its guaranty, that in the activities outlined every physician in the state may take a deep and abiding pride that the House of Medicine has continued the program which has made it so outstanding in the service of its country's needs.

Civilian Defense

The basic Emergency Medical Service organization ground work which was begun in 1941 and 1942 has been continued in 1943. Due to demands made upon his time and energy by the Procurement and Assignment Service, Dr. R. E. Fitzgerald resigned as State Chief of Emergency Medical Service, and his duties were assumed this summer by Dr. J. S. Supernaw, who was appointed State Chief of Emergency Medical Service by the Honorable John Cudahy, Director of the Wisconsin Council of Defense.

The basic work of securing the establishment of first-aid post units and the equipment for casualty stations as prescribed by the Office of Civilian Defense has been carried forward in many communities in Wisconsin.

Target Areas

The United States Army, in collaboration with the Office of Civilian Defense, designated several communities in Wisconsin to be recipients of supplies to augment the facilities already brought together by the County Chiefs of Emergency Medical Service located in those areas. These communities are generally referred to in civilian defense circles as "target areas." The supplies being forwarded to these communities include equipment for medical teams, equipment for casualty stations, stretchers, cots, first-aid pouches, gas masks, protective clothing, and morphine. The morphine, which is being distributed by the Office of Civilian Defense, is prepared in an especially designed ampule which is, in fact, a self-contained syringe. The vial is equipped with a needle, and the morphine in the ampule is under pressure, and when the neck of the ampule is broken, the morphine is injected into the body by the pressure contained in the vial.

Emphasis will continue to be placed on the organization of Emergency Medical Service in the target areas and the areas immediately adjacent to them.

Affiliated Units

Upon the request of the United States Army, the Office of Civilian Defense, in cooperation with the United States Public Health Service, has requested that there be established throughout the United States a number of affiliated units. Many such units have already been formed in the United States, but a limited number were requested for establishment in Wisconsin. The affiliated units are composed of a corps of approximately fifteen physicians and in excess of twenty nurses. They are to be used to staff hotel hospitals already selected by army personnel to be activated in the event of a disaster. The medical personnel will receive a commission (inactive) in the United States Public Health Service for duty in the Sixth Service Command (Wisconsin, Illinois, Michigan), but service outside the boundaries of Wisconsin would be highly improbable. These units would be activated only upon the direction of the Regional Medical Officer and the State Chief of Emergency Medical Service.

Invitations have been extended to form three affiliated units in Wisconsin, one at each of the two medical schools (Marquette and Wisconsin) and a joint unit formed from the staff of three Madison hospitals, Madison General, St. Mary's and the Methodist.

Unit directors have been nominated for each of these units, and the formation of the medical personnel for the units is now under way.

Blood Plasma

Blood plasma grants were made by the Office of Civilian Defense to Superior, Eau Claire, and Madison. Grants were tendered other Wisconsin communities but were declined.

There are now available in Wisconsin over 1,500 units of blood plasma located in strategic points in Wisconsin. Additional units are either definitely allocated to Wisconsin or in the course of preparation, which will result in the maintenance of a constant supply of over 2,000 units that can be used in the event of major community disasters. A complete resumé of the availability of blood plasma was contained in the July issue of *The Wisconsin Medical Journal* in the "Nation at War" section.

Gas Warfare

The Office of Civilian Defense has emphasized the need for special training of Emergency Medical Service personnel in the treatment of patients injured as the result of gas warfare. The Office of Civilian Defense has urged that the State Chief of Emergency Medical Service, in cooperation with the medical schools, develop an intensive program of postgraduate medical education on this subject. Representatives of the two schools attended special training centers on The Medical Aspects of Chemical Warfare, and these representatives, together with the State Chief of Emergency Medical Service and the Council on Scientific Work, have reached a joint conclusion that the initial gas warfare schools for Wisconsin physicians should be presented in those cities that have been designated as target areas. Thereafter, consideration will be given to the presentation of these postgraduate medical courses in those areas that have been designated as "second priority" communities.

Other subjects to receive the careful consideration of Emergency Medical Service during the last year have been plant protection, distribution and allocation of Emergency Medical Service equipment, and advising and counseling local Chiefs of Emergency Medical Service on problems which have arisen in their local communities.

6. REPORT OF SPECIAL COMMITTEE OF THE PRESIDENT

ADVISORY COMMITTEE TO THE STATE DEPARTMENT OF PUBLIC WELFARE

H. K. Tenney, H. L. Greene, H. W. Mason, J. L. Garvey, W. A. Munn.

Every physician in the State of Wisconsin is appreciative of the fact that at the present time there is a coordinated and active approach to the problems concerned with the affairs of those unfortunates who may be committed to the various institutions under the direction or supervision of the State Department of Public Welfare. It has long been appreciated by the medical profession, as by others, that in the management of the medical problems and of the fundamental problems of care and surroundings which are directly related to the health welfare of its patients, the State of Wisconsin has not at all times been either realistic or devoted.

Under the impetus given the subject by one of the members of the State Board of Public Welfare, an invitation was issued to the State Medical Society of Wisconsin to create a special advisory committee to cooperate with that department in considering those medical problems of particular concern, not alone as they exist today but as they may exist or be created in the future planning for the welfare of these patients.

Acting upon the approval of the Executive Committee of the Council, the president of the State Medical Society of Wisconsin appointed this committee, which was privileged to meet in July, 1943, with the State Department of Public Welfare to ascertain its duties and responsibilities. As a result of that meeting, certain problems have been referred to the committee which will be the subject of discussion and study by it and of constant and regular reports to the medical profession and to the State Department of Public Welfare as may be dictated by their inherent characteristics.

At this point the committee advisory to the state department is not in a position to present to the House of Delegates and members more than the reason for its appointment, the cause with which it is charged, and the procedure by which it hopes to offer the cooperation of the entire profession in meeting problems of utmost importance and of distressing significance.

The House of Delegates will meet on three occasions during the course of the meeting. The first session will convene at 5:00 p. m., Sunday, September 12; the second at 6:45 p. m., Monday, September 13; and the final session at 8:00 a. m., Tuesday, September 14.

The Committee on Public Policy

C. A. Dawson, chairman, S. E. Gavin, J. C. Sargent, (in service); Gunnar Gundersen, alternate for Dr. Sargent; president, president-elect and secretary (ex officio)

Introduction

ON JANUARY 12, 1943, there convened in Madison the Sixty-Sixth Regular Session of the Wisconsin Legislature. Technically, the session has not ended, both houses having recessed June 18 and again on July 14. The session resumed on August 3.

Close as is your committee to a legislative session which has technically not yet adjourned, it may be said without reservation that the Sixty-Sixth Regular Session will long be memorable in the minds and annals of those interested in public health in Wisconsin. Every legislature has had able and courageous leadership. Wisconsin has been fortunate also in its chief executives, but what distinguished the 1943 session was not only the outstanding character of its legislative and executive leadership but the sustained and unmistakable interest in public health which was evidenced by a majority of the members of all parties and of both houses.

For this, credit is due not only to the legislators themselves but also to the carefully developed program of facts and education which has always been the essence of our Society's legislative efforts. The leadership of this Society has long felt, to quote our late secretary, George Crownhart, that "the interests of public health are identical to those of medicine. Whatever will promote the public welfare, whatever will protect the advances made,—these are medicine's only objectives."

That is but another way of saying that both medicine and public health have everything to gain and nothing to lose from the truth. That is why your committee, as the legislative representative of our Society, has ever insisted that immediate success, where necessary, must be sacrificed to the long range program of explanation and of education, so that knowledge may be substituted for prejudice.

To summarize, it has been both a stimulating and a heartening experience to note in the Governor of our commonwealth, in the president pro tempore of the Senate, in the speaker of the Assembly, in the chairmen of important legislative committees, some of which seldom if ever had had medical or public health legislation, as such, before them, and in the membership at large, repeated evidence of an abiding and sincere devotion to sound public health standards and to their safeguarding and preservation.

A total of 1,124 bills, exclusive of resolutions, has been introduced thus far in the 1943 session. As of this date, nearly 550 of them have been enacted into law. It appears unlikely, at this date, that there will be an effort to do more than to consider a remaining few bills, all others previously undisposed of having been indefinitely postponed in both houses on June 18, the last day before the summer recesses began.

As has been the experience of our Society in previous sessions, about 10 per cent of all legislative proposals were found to affect the public health, either in a general or in a specific manner. Of this total number of some 120 bills, which were followed by our Society and its Committee on Public Policy, some thirty or forty could be termed of importance. As was true of previous sessions, each measure introduced in the two houses of the legislature, together with all amendments, were carefully read and analyzed under the established policy that "the field of Society interests in legislative proposals is just exactly as broad as the field of the public health itself."

Annual Reregistration of Physicians

In accordance with the action of the House of Delegates at its 1942 session, Assemblyman D. I. Hammergren of Buffalo–Pepin County introduced on behalf of the Society a bill providing for annual reregistration of physicians and osteopaths. This bill was well supported by the committees and by the general membership of both houses, having passed the Assembly by a

vote of 83–3 and the Senate by a vote of 24–0. Upon its approval by the Governor on May 19, 1943, it constituted the realization of an important part of the program of many of the leaders of our Society.

A repetition here of the full details of the bill and of its purposes does not seem warranted in view of the earlier legislative reports to the membership and of the article on the bill which appeared at page 619 of the June, 1943, issue of *The Wisconsin Medical Journal.* However, a few of the important reasons for the enactment of the bill may be restated. Perhaps the first is that annual registration permits an accurate and up-to-date inventory of physicians available for active practice in Wisconsin. That information is now largely guesswork. It is vital to know our physician inventory in wartime, and it will be no less important in the postwar period, when physicians return to their communities and when local populations tend to return to prewar levels. Second, the law provides the State Board of Medical Examiners with more nearly adequate funds for enforcement of the Medical Practice Act and thereby protects the sick public and its pocketbook from the unlicensed or unqualified practitioner. Approximately one-half of the states in the nation have annual reregistration acts, including our sister state of Minnesota. The Minnesota law has been followed in part, and every effort has been made to make the Wisconsin law simple and easy to administer.

Annual reregistration will begin in January, 1944. The State Board of Medical Examiners will undoubtedly busy itself with preparation of necessary forms and other preliminary matters in the very near future. It is believed that this is an important and forward looking piece of legislation, and it was gratifying and encouraging to note the ready and almost universal support which was accorded the bill by both branches of the legislature, as well as by the executive office.

Emergency Medical Care

A second important piece of legislation enacted during the current session was a bill relating to emergency medical relief and introduced by Speaker Vernon W. Thomson of Richland County at the request of the Society. As the Society membership is aware, the statutes now make a town, city, village, or county liable for hospitalization of a relief case in an emergency without prior authorization when in the physician's opinion immediate hospitalization is required for indispensable emergency operation or treatment and prior authorization could not be obtained without delay likely to be injurious to the welfare of the patient. Strangely enough, although hospitalization was thus provided for, medical care was not, with the anomalous result that the same physician who made the decision that emergency hospitalization was required and who could, by virtue of such decision, obligate the municipality to pay for such hospitalization without prior authorization was himself unprotected so far as his right to recover for his own services was concerned.

The statute as amended by the new law now provides not only for hospitalization but also for care rendered by a physician and surgeon. The hospital was formerly and is still required to give notice to the proper public officer of the fact of admission of an emergency relief patient within twenty-four hours after such admission. The attending physician must, under the amendment, give similar notice to the proper official in order to obligate the municipality for the payment of reasonable fees to him. This equitable new provision of the statute is very much in the public interest, since it leaves the situation as it should be, namely, one in which no technical legal requirements of authorization need concern the physician in treating initially an emergency relief case when the delay in securing such authorization might be injurious to his patient's welfare. He can first arrange such hospitalization and medical care as patient needs require and later take care of technical authorization details.

State Board of Health Salaries

Your committee is pleased to report that some recognition of the importance of the work of the state health officer and his deputies was reflected in the enactment of two bills into law during the current session.

Both were introduced at the request of your Society by Senator Wm. A. Freehoff of Waukesha. One of these raised the salary ceiling of the state health officer from $5,000 to $6,000, and the other raised the salary ceiling for deputy health officers from $3,000 to $4,000. While your committee would like to see both of these ceilings raised still higher, it is felt that a good start has been made. It is the hope of your committee that modest as these increases are, they may help preserve both morale and personnel in the State Board of Health, which is of such vital importance to the physical well-being of our entire population.

Licensed Attendants

As every practicing physician knows, the shortage of registered nurses is increasingly acute and will inevitably become even more so as combined military and industrial demands leave fewer and fewer nurses available for hospital and home duty. In recognition of this fact, your Society, together with the Wisconsin Conference of Catholic Hospitals, the Wisconsin Hospital Association, and the Wisconsin State Nurses Association, introduced a bill rather late in the session providing for the creation of a new category of nursing assistant to be known as a "licensed attendant." This category is already recognized in some twelve other states of the country under statutes which, in some cases, are more than twenty years old. The licensed attendant is neither a practical nurse, an ordinary institutional attendant, nor a registered nurse. Neither is she a "nurse's aide" as that term is commonly understood in many hospitals of this state at the present time. Rather, she is a person trained only to perform simple procedures in the physical care of the patient, and she may perform other procedures only under the direction of the attending physician. She may be trained only in schools licensed by the Committee on Nursing Education; her training will cover a period of nine to twelve months; and the Committee on Nursing Education may, in its discretion, waive the requirement of attendance at such school when it deems the applicant to have had equivalent training. An applicant for licensure must also pass an examination to be given by the Board of Examiners for Nurses and must register annually.

It is hoped that a number of hospitals will be interested in qualifying as schools for the training of licensed attendants and that the training may appeal to a substantial number of young women who may lack either the desire or the finances to take the much longer course required for professional nurses. The training of licensed attendants may afford substantial relief in this period of shortage of nurses by permitting the substitution of the licensed attendant for certain types of home cases and hospital work, thus releasing a professional nurse for administrative, supervisory, or other more important duties.

Socialized Medicine Program

In recent legislative sessions, two perennial favorites of the group which favors state medicine have been bills designed, respectively, for the establishment of a system of compulsory health insurance and for the establishment of so-called health cooperatives. The two bills have been summarized by your committee in its 1937, 1939 and 1941 reports and were substantially unchanged this year. The Assembly Committee on Public Welfare, of which the chairman is Mr. Earl W. Hanson of Elk Mound, scheduled these bills for joint hearing on April 14. The hearings were rather protracted, the advocates of the bills consuming approximately one and one-half hours in their efforts to explain them. The secretary of our Society made the presentation on behalf of medicine and was followed by a legislative representative of the Wisconsin State Dental Society.

Our secretary, by leave of the Chairman of the Assembly committee, combined his presentation on the two bills, thus making possible a more coherent presentation and a more thorough exposition of the sameness of the underlying philosophy behind each bill. The full report of the hearing was printed as a special insert section in the May, 1943, issue of *The Wisconsin Medical Journal.*

Our secretary emphasized at the outset of his presentation on the two bills that what the proponents of the bills were really doing

was to propose changes in our economic system. To quote his own words, "You cannot create a system of socialized medicine without, at the same time, creating a large government payroll, acquiring property, forming habits and attitudes, and these, once created, resist change and warp judgment." He also emphasized that the practice of medicine is a part of our socio-economic society and that we would do well to weigh carefully what we have done and what we now have before we trade the present system for something else. He proceeded with detailed explanation of some of the outstanding health achievements of Wisconsin which have been beneficial to our entire population, all of which have been achieved under a system of private medicine with carefully coordinated public health services. Emphasis also was given to the fact so often overlooked by the disciples of a new social order, namely, "that the delivery of medical care and its allied services is not the delivery of a commodity." He emphasized the special skills and the long training which are the essence of private medical practice, pointing out that medicine is effective only to the extent it is individualized and that individualization involves the dedication by the individual physician of himself and of his professional abilities on what amounts to a twenty-four hour basis rather than on the basis of performance of such duties as are required by an eight-hour civil service shift.

Compulsory Sickness Insurance

Turning to the bill which would have set up a compulsory sickness insurance system for Wisconsin, our secretary pointed out that at least one-third of the workers of the state would have been excluded from its asserted benefits and that at least one-third of the general population of Wisconsin which would have been the dependents of such excluded workers would likewise be deprived of what the bill was assertedly designed to achieve. Careful studies indicated that the bill would raise, initially, not less than about $34,000,000 per year, or approximately $17 per person covered by the bill. Incidentally, this figure of $34,000,000 a year is very nearly as large as the entire state budget adopted by the 1943 legislature and approved by acting Governor Goodland. Yet, large as is this initial sum, it was emphasized that after deduction of the minimum of 20 per cent to 25 per cent for administration and for necessary reserves, the net figure of some $12 actually available to the persons covered by the bill would be almost one-half less than that which has been indicated to be the minimum necessary for any sound system of health insurance. Something over $20 is estimated as that necessary minimum, yet under the proposed bill it was difficult to be assured of as much as $12 for actual medical and other health services.

It was pointed out that the approximately 840,000 workers in this state who would come within the terms of the bill would feel that out of the 4 per cent deduction contributions made equally by employer and employe which would be required to finance the proposed public health system, *adequate* medical care with all that is implied in that term would be *guaranteed* them. Analysis of the wording of the bill offered no such assurance, wholly aside from the fact that examinations of systems of socialized medicine elsewhere certainly afford no ground for any such optimism. Stress was also laid on the dictatorial powers given the director of the public health insurance plan, and the fear was expressed that the system could well degenerate into an overwhelming mass of involved rules and the conservation of reserves, rather than a system of genuine public health insurance.

It was suggested, in conclusion, that the system of care proposed by this bill inevitably put fiscal health ahead of public health.

In closing, our secretary pointed out a fact which is obvious to any student of the problem and a fact well known to the present generation of physicians which carried the relief burden of the past decade, that in the last analysis it is the medical profession which is the real reserve of the compulsory sickness insurance scheme.

Health Cooperatives

Our secretary next gave attention to the other bill, which was also a Biemiller bill in earlier sessions and which was designed to

authorize the establishment of so-called health cooperatives. First of all, he noted that the bill contained purported findings by the legislature which were not, in fact, the findings of the legislature. He noted that somewhere in excess of 100 insurance companies are already licensed in this state to write accident and health insurance paying cash benefits, thereby discrediting the statement that "no arrangements exist for spreading the risk of medical and hospital expense over groups of people and periods of time."

Continuing with the analysis of the bill, our secretary pointed out the reference later in the bill to denial of hospital facilities, stating that the reasons for such limitations as did exist were built up solely on principles of sound medical care to the end that the patient might realize maximum benefit from his hospitalization.

After pointing out other serious flaws in the proposed bill and the fatal weakness of a system which would permit the loose formation of lay groups to dominate rendition of medical care, our secretary closed with a reference to the Beveridge Report which has been the subject of so much discussion and so little reading during the last six months. He noted that Sir William Beveridge was very frank in his famous "Cradle to Grave" report about his desire to cover 100 per cent of the population and his admission that the possible scope of private practice "will be so restricted that it may not appear worth while to preserve it."

To offset the underlying philosophy of the paternalistic and socialistic Beveridge Report, he quoted from a recent American economist who stated, after participating in detailed health surveys of this country and after viewing critically the various types of ready-made social security systems, "There must be a better way of life than that, and we believe the American people will insist upon finding it."

Your committee joins unreservedly in saying "Amen" to the statement above quoted, for it is our conviction that it represents and becomes the American way of life infinitely better than a system transplanted from foreign soil. Your committee is gratified to report that both of these bills were recommended for indefinite postponement by the Assembly Committee on Public Welfare, that the health insurance bill was in fact indefinitely postponed by the decisive vote of 58–30, and the health cooperative bill by the equally satisfactory vote of 50–27.

Chiropractic Legislation

As was true during the 1941 session of the legislature, the chiropractors of this state during the current session sought to take advantage of the times and of the national emergency in a desperate effort to have enacted some of the special interest legislation which they have introduced in prior sessions.

The first of their bills provided that the Board of Examiners in chiropractic were to offer examinations in the basic sciences to persons seeking a license to practice chiropractic. The obvious purpose of the bill was to remove candidates for the practice of chiropractic from the jurisdiction of the present Basic Science Board, which, under the present statute, examines candidates in all the healing arts without distinction. The probable reason for this is the extreme difficulty which chiropractic candidates are said to have in passing the basic science requirements.

It should be recalled that the Basic Science Board, which was created by a 1925 law, is composed of three persons having no connection with any school of healing. It should also be noted that chiropractors themselves have stated that approximately 90 per cent of the chiropractors now licensed to practice in Wisconsin are entitled to practice not by virtue of any examination but by virtue of the so-called "grandfather's clause" which was inserted in the 1925 act. It was obviously not in the interests of sound public health to permit the transfer of the right of examination in the basic sciences from a competent and neutral board, whose thoroughness and integrity stand unquestioned after almost two decades, to a board composed exclusively of cultists who would later have the licensing power in their particular cult. Medicine would be equally justified in ask-

ing a transfer of basic science examinations for medical candidates to the State Board of Medical Examiners. This bill was indefinitely postponed by the overwhelming vote of 69 to 20.

As in the 1939 session, the chiropractors also had introduced a bill which would have permitted them to use the titles "Doctor" or "Doctor of Chiropractic" or abbreviations of either of such titles. Our Society was opposed to this measure in the interests of sound public health, emphasizing, as it has on so many other occasions, the confusion which exists in the minds of so many of the public, particularly those of foreign birth or limited education, when the title "Doctor" is used by anyone other than one licensed to practice medicine and surgery, osteopathy and surgery, or dentistry. In fairness to the author, it should be noted that the bill was withdrawn and returned to him on his request.

For the seventh time in seven successive sessions, the chiropractors sought enactment of a bill, introduced in the Senate, which would permit an employe to select a chiropractor who was not on a workmen's compensation panel, with attendant liability on the part of the employer for the "medical services and treatment" so furnished by such a chiropractor. The argument was offered by proponents of the bill that because of the "shortage" of physicians at the present time, the chiropractors stood ready to assist in the war effort by tendering their services to industry en masse. It will be interesting to speculate on the arguments which will be offered when the war is over.

In the Assembly there was not only a proposal that an employe had the right to select a chiropractor not on the workmen's compensation panel, with attendant resulting liability on the part of the employer, but the question whether the provisions of that bill were to take effect was to be submitted to the people of Wisconsin by referendum in 1944 on a ballot which would have given no indication of the real content of the bill itself. After the Assembly hearing on this bill, an amendment was offered on the floor of the Assembly striking out the referendum features and giving an employe an option to elect chiropractic treatment along with Christian Science in lieu of medical treatment if the employer had not filed the statutory notice of his unwillingness to permit either of such treatments in compensation cases. This bill was indefinitely postponed by a vote of 50 to 30.

Postwar Rehabilitation

A considerable number of bills was introduced looking to the postwar rehabilitation of returning veterans. It is clearly intended that the term "rehabilitation" be broadly construed and that it include medical, institutional, educational, and other care and facilities for those having need of them. Funds for the financing of such rehabilitation were earmarked in amounts which have been variously estimated at between $17,000,000 and $35,000,000.

Among the bills dealing with rehabilitation was one which created a Veterans' Recognition Board, and your committee desires to note in passing that medicine has been honored by having a member of our Society named to one of the five places on that board. The position carries no compensation but confers on its members broad policy-making powers which may have far-reaching significance to beneficiaries of the legislative program and their families.

Vital Statistics

A number of bills were introduced in the current session relating to vital statistics and the manner in which they are to be gathered and reported. This includes births, deaths, marriages, and certain industrial and communicable diseases. The necessity for identification as a condition of employment in war industry has made the general populace conscious of the importance of adequate birth records, while the usefulness and practical necessity for the other figures becomes increasingly apparent to all well informed citizens. The State Board of Health sponsored a bill designed to modernize and restate the statutory machinery for the gathering of vital statistics. While the matter is still in a somewhat unsettled state, and the administrative consequences of the provisions of certain bills cannot yet be foretold

with accuracy, it is believed that the corrective and modernizing features of the bills were steps in a sound direction.

Poor Relief

At the present time, the subject of poor relief is not of the relative importance which it was during the past decade. The problem never ceases to be important, however, to that reduced number which now requires its benefits and to that unknown number which may at some future time require them. That the subject had not lost its significance in the legislative mind was evidenced from the number and variety of proposals made during the current session. It may be noted as to the bills themselves that the beneficent purpose underlying Wisconsin relief statutes was sought to be continued in the proposed legislation. Earlier in this report there was a summary of a bill sponsored by our Society relating to medical care rendered in emergency relief cases. A joint resolution was adopted looking to the study and possible codification of the relief laws of this state. There is every reason to anticipate a painstaking and socially desirable survey on the part of this interim committee with consequent valuable suggestions for the 1945 session of the legislature.

Miscellaneous

Time and space do not permit detailed reference to other legislation which had either direct or indirect public health implications, all of which was followed with interest by our Society. Suffice it to say that these other bills covered a diversity of fields bearing upon the health and the physical and mental comfort of substantial sections of the public.

These bills included several relating to insanity and institutionalization for that condition; the antenuptial physical examination of women; enlargement of powers of hospital service corporations; a proposal relating to the clearance, replanning, reconstruction, and rehabilitation of unsanitary and blighted areas of cities following the war; bills relating to the practice of optometry and requirements in this field; the setting up of statutory tests for intoxicated drivers based upon the chemical analysis of the blood, breath, urine, or other bodily substance of the accused person. This list is by no means inclusive but is intended rather to be indicative of the breadth of the subjects encompassed by legislation proposed in the course of the current session. The summary does not indicate in any manner the amount of careful analysis and study which go into the budget bill, the revenue bill, and the always frequent amendments to both of these bills in each session. The Society is ever interested that adequate funds be available to to all state institutions but in particular to those which care for the physically and mentally infirm, whether such infirmity springs from disease, injury, old age, or other cause.

Neither does this summary take into account the extent to which our Society is called upon in a consulting capacity for the furnishing of factual data and for the judgment of its leadership in connection with proposed and pending legislation. Your committee has enjoyed no more gratifying experience than to be requested upon one occasion after the other, sometimes by legislators, sometimes by groups of a business, trade or other character, to furnish the benefits of its studies and of its collective judgment on various proposals and their soundness. This is a real tribute to the long years of sincere devotion to the educational ideal which is the essence of our legislative policy.

Legislation in a Democracy

In closing, your committee would like to leave a few rather informal but nonetheless sincere thoughts with the membership to which it is reporting. We wish to emphasize first of all that despite all propaganda or intimations to the contrary, it is satisfied that the local family doctor continues to occupy a very high place in the esteem both of the general public and of the legislator. It is our most devout wish that the physician may continue to merit that esteem by both his professional acts and his sense of civic responsibility.

The second thought which your committee wishes to leave with its fellow-members is the responsibility devolving on every physician as a representative member of his community of keeping alive to public needs

and contributing of his time and his ideas, wherever possible, to the solution of public problems. Physicians need to participate much more than they have in the active functioning of their government. It is believed that they can expect to bring the government a little more of the "scientific spirit" than has sometimes characterized our political scene.

Third, while we know full well that the responsibilities and pressures on the physician during this period of war are so heavy as sometimes to seem beyond human strength, the physician is under duty not to lose his sense of values and of proportion. Governments are ultimate developments from neighborhoods and local communities. Unless a high degree of personalization is retained, government tends to become abstract and nonrealistic. It is very important that legislatures continue to meet in wartime and that they continue to be concerned with and seek the solution of the many pressing local problems of human needs, developments, and comforts which can be solved partially at least by sound legislation. It is the function of the individual physician far more than it is the obligation of organized medicine as such, to make his voice felt in the consideration of programs for social betterment. In making his ideas vocal, the physician should speak and should be considered not so much in his professional capacity as in that of a highly educated, interested, and responsible citizen. He owes it to the community of which he is a part to give back by writings, by conference, or in other ways some of the benefits which that community made available to him in the special training and schooling which prepared him for his chosen work. In brief, the physician is as fully obligated to be a good citizen and to participate actively in public affairs in the fine full sense in which that term is here used as to be a capable and ethical practitioner of his profession.

By his sustained interest, his continuous study, and the many forms of participation in public affairs which are open to him without the necessity of his holding public office, the physician can be a strong and a stabilizing social force in his community as well as a valued family and personal adviser.

The committee accepts the responsibility of speaking for all of you in broad general terms. It cannot hope, however, to act effectively for all of you or to serve as substitutes for what each of you is capable of offering in your own community to the solution of community problems. Sound legislation is not a matter of spontaneous combustion. Rather it is a matter of gradual evolution growing out of the recognition of a problem, sometimes by a legislator, sometimes by a business, administrative, or other group, perhaps more often by small, intelligent citizens groups.

Constructive reading, constructive thinking, and constructive discussion must continue to be the principal sources of sound legislation if we desire to keep this nation a democracy in the true sense rather than a government ordained by a self-seeking few. Should the latter ever come to pass, physicians will of necessity have to share along with other citizens the responsibility for helping bring about a condition based upon civic inertia and indolence. Your committee closes in the full confidence that the American man of medicine will never forget his paramount duties as a citizen and will never forget that among the foremost of those duties is a continuing and constructive interest in sound legislation.

NO REGISTRATION FEE

Because of the revenue received from the technical exhibitors for exhibit space, it is possible for you to attend the One Hundred Second Anniversary Meeting without paying a registration fee. If it were not for this revenue, the per capita cost for physicians attending the meeting would be from $4 to $5.

These firms have a genuine message for you; both the exhibitors and you will be repaid many times if you stop at their booths.

News Items and Personals

Dr. Byron M. Caples, who has been a physician in Waukesha County for over fifty years, announced his retirement as head of Waukesha Springs Sanitarium, Waukesha, in June. The announcement accompanied the news of the sale of part of the Sanitarium property to Carroll College, which had experienced a housing shortage when cadets of the Army Air Corps were assigned to the college several months before. Dr. Caples' retirement and the sale of the main building of the Sanitarium mark the end of the operation of the institution, which was established by Dr. Caples in 1898 after he had studied psychiatry in Europe.

Dr. Caples, who is 83, plans to continue his practice in Waukesha and to run a thirty acre farm on the outskirts of the city.

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Dr. Erwin C. Cary, Reedsville, has been reappointed health officer for the village of Reedsville and also for the towns of Rockland and Franklin. He was recently re-elected president of the Manitowoc County Health Officers' Association.

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The Banker's Building is the new location of the offices of *Dr. David J. Ansfield* and *Dr. Maurice J. Ansfield* in Milwaukee.

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Election to membership in the International College of Surgeons was the honor recently bestowed upon *Dr. Victor F. Marshall*, Appleton. He was inducted in absentia into the College on June 15 in a ceremony at the Waldorf–Astoria Hotel in New York, where the College held its annual meeting.

Dr. Marshall is also a member of the American College of Surgeons and the American Board of Surgery.

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Addressing the first class of nurses' aides in Burlington to receive their caps and pins, *Dr. John F. Bennett*, chief of the medical staff of the Burlington Memorial Hospital, expressed deep concern for what he considers a decline in the ethical training of the medical and nursing professions. He stated, "It is my honest conviction that while scientific discoveries have increased the span of life and saved many lives in the present emergency, these do not entirely compensate for the failure to live up to proper rules and principles of guidance in carrying on our work."

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Dr. E. H. Spiegelberg, Boscobel, delivered a lecture on cancer in the Old Academy Building, Patch Grove, on Sunday evening, June 20. The talk was followed by a series of slides on the subject, "Accidents in the Home," shown by Miss Constance Carmody of Mt. Hope, Grant County nurse.

At the fourth annual meeting of health officers held Tuesday, June 12, at the Fayette Hotel, Medford, a general round-table discussion comprised the program from 10:00 to 12:00 a. m.

After luncheon, *Dr. Harry M. Guilford*, director of the Bureau of Communicable Diseases and Social Hygiene of the State Board of Health, Madison, spoke on scarlet fever, typhoid fever, and trichinosis.

Dr. Frances A. Cline, health officer of District No. 8, stated that whooping cough is causing more deaths than are small pox, diphtheria, and scarlet fever combined. She emphasized the necessity for effective protection of infants and older children against whooping cough by means of immunization.

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Three Waukesha County physicians who have practiced for over fifty years and are still active were honored by the Waukesha County Medical Society at Draper Hall, Oconomowoc, Wednesday evening, June 2. They are *Dr. Michael R. Wilkinson*, Oconomowoc, *Dr. Byron M. Caples*, Waukesha, and *Dr. Francis J. Donnelly*, North Lake. Preceding the banquet, each was awarded an honorary life membership in the county society in the presence of fifty-five members of the organization and its auxiliary.

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At the request of the State Board of Public Welfare, *Dr. Russell M. Kurten*, president of the State Medical Society of Wisconsin, appointed an advisory committee to meet with the board members and study existing problems and policies affecting the state institutions. The new advisory committee, made up of *Dr. H. Kent Tenney*, Madison, *Dr. Henry L. Greene*, Madison, *Dr. Elwood W. Mason*, Milwaukee, *Dr. John L. Garvey*, Milwaukee, and *Dr. Wayne A. Munn*, Janesville, held its first session Thursday, June 24, at the Southern Wisconsin Colony and Training School, Union Grove.

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On Thursday, June 17, the fire and police commission of the City of Milwaukee confirmed the appointment of *Dr. Albert Popp* of that city as a police physician and surgeon. Dr. Popp, a graduate of the Marquette University School of Medicine, succeeds the late Dr. David Mehigan.

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At a meeting of the New London Lion's Club on Tuesday, June 22, *Dr. John W. Monsted*, New London, showed the film "Peptic Ulcer."

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Dr. Leslie G. Kindschi of the Monroe Clinic, Monroe, has been certified as a specialist in internal medicine by the American Board of Internal Medicine. He received his degree in medicine from Harvard University in 1935 and interned at the Cleveland City Hospital. For four years he was with the

Mayo Clinic at Rochester. He went to Monroe from Madison in May, 1941, and has been in Monroe since that time.

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Foreseeing even as early as 1940 a national need for expanded shipbuilding facilities, *Dr. Clarence H. Boren*, Marinette, has brought about the construction of a shipyard in Marinette, a site which to most people had once seemed too far away to handle any of the nation's marine requirements. Incorporated on April 14, 1942, with Dr. Boren as president, the Marinette Marine Corporation has been awarded contracts by the United States Maritime Commission for the construction of both barges and tugs.

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On June 21, the Office of Civilian Defense, Washington, D. C., announced that the Madison General Hospital, the Methodist Hospital, St. Mary's Hospital, and the University of Wisconsin Medical School, all of Madison, had been invited to form units of civilian physicians to assist in war emergencies. These units will be called upon to assist the army temporarily if it is unable to handle a sudden influx of war casualties. The physicians to be used are those in affiliated hospital units which have been organized by the Office of Civilian Defense and the United States Public Health Service.

So that formation of Office of Civilian Defense units will not conflict with regular military procurement of physicians, applications are accepted only from physicians 45 years of age or over, women physicians, physicians who are physically disqualified for military duty, and physicians already declared by the Procurement and Assignment service to be essential for civilian needs.

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On July 2, Acting-Governor Goodland announced the appointment of *Dr. Charles A. Dawson*, River Falls, to the newly created Veteran Recognition Board.

The board will have charge of handling the $6,300,000 delegated by the legislature for the educational, medical and economic rehabilitation of World War II veterans of Wisconsin and their families, as well as any other state or federal funds set aside for such rehabilitation.

Members of the board will receive no salary for their services but will be paid their expenses. The board is authorized to name a $6,000 a year director and staff to administer the funds. The staff will be under civil service.

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The election of *Dr. Gunnar Gundersen*, La Crosse, as president of the Wisconsin State Board of Health and *Dr. Ira F. Thompson*, Racine, as vice-president was announced on July 13.

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At a meeting of the staff of the Theda Clark Memorial Hospital, Neenah, on Friday, July 2, the following Neenah physicians were elected as officers:

President—*Dr. Matthias N. Pitz*
Vice-president—*Dr. George E. Forkin*
Secretary-Treasurer—*Dr. J. P. Canavan*

Lieutenant Frederick G. Jensen, Menasha, of the United States Naval Reserve is the retiring president.

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Ending fifteen years as a physician in Eagle River, *Dr. Ora R. McMurry* has begun practicing at Greendale, the model village near Milwaukee, where he will have not only his private practice but will also serve as village health officer. Although Greendale is a community of 27,000 persons, up to this time it has been without a doctor.

Dr. McMurry is a graduate of the University of Wisconsin and received his degree in medicine from the University of Pennsylvania. He spent his internship at the State of Wisconsin General Hospital, Madison. During World War I, he was in the United States Air Corps and served in France, where he received the Distinguished Service Cross.

Prior to his residence and practice in Eagle River, he was working under the Wisconsin State Board of Control in the psychiatric field service.

In Eagle River he was frequently referred to as "Eagle River's Flying Doctor" because of his active interest in flying. It was through his interest that the airport facilities of Eagle River and Three Lakes were developed.

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The Sun Prairie branch of the Jackson Clinic of Madison was discontinued on July 1 for the duration because of the shortage of doctors and the extra work imposed on those remaining. The two physicians who have been in charge of the office, *Captain Norman Barnstein* and *Captain Byron Gutheil*, are now in active army service.

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Dr. Elmer A. Schmidt, formerly consultant and surgeon for the hospital of the United States Department of the Interior at Tomah, has begun practicing at Beaver Dam. A graduate of the Marquette University School of Medicine, Dr. Schmidt served his internship at St. Mary's Hospital, Milwaukee, and later served as resident physician at the Shorewood Hospital–Sanitarium and as resident surgeon at the South Milwaukee Hospital before going to Tomah.

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A recent issue of *The Wisconsin Magazine of History*, published by the State Historical Society, contains an article on "Early Beloit Physicians" written by *Dr. Harold M. Helm*, Beloit, who represents the third generation of his family to practice medicine. The article traces the story of the "country doctor" in Beloit from 1836 to the present time. In writing of the numerous physicians who practiced in Beloit, Dr. Helm tells not only of their hardships in pioneer days but also about their amusements, diversions, and individual eccentricities.

Because of a shortage of interns in civilian hospitals, Madison physicians belonging to the staffs of Madison General Hospital and St. Mary's Hospital, Madison, are taking turns serving as night interns in their respective hospitals from 7:00 p. m. until 7:00 a. m. The system started July 1 in both hospitals. Instead of serving as hospital interns for one year before entering practice, graduates of medical schools at the present time generally step directly from the campus into the armed services as officers and serve their internships in the uniforms of the Army, Navy, and Marine Corps.

Society Proceedings

Pierce—St. Croix

The Pierce–St. Croix County Medical Society held its monthly dinner meeting in Hudson on Thursday evening, June 17, at the Hotel Hudson. Dr. Alfred Hoff, heart specialist of St. Paul, Minnesota, was guest speaker.

Polk

On Thursday evening, May 20, the members of the Polk County Medical Society met at "A Little Bit of Sweden," Taylor Falls, Minnesota, where they were entertained at dinner by Dr. Henry C. Caldwell of St. Croix Falls.

A business meeting followed the dinner.

Portage

The Portage County Medical Society held its last meeting for the summer at Eske Lodge, Stevens Point. The scientific program which followed the dinner was featured by a talk on "Recent Advances in Therapy" presented by Dr. Ovid O. Meyer of the University of Wisconsin Medical School, Madison. The remainder of the evening was spent socially.

Price—Taylor

At the annual meeting of the Price–Taylor County Medical Society Thursday, July 22, Dr. Henry A. Sincock, Superior, guest speaker, discussed gastrointestinal disorders in children.

Present at the meeting was Mr. Robert B. Murphy, legal counsel for the State Medical Society, who explained the proposed Farm Security Administration medical care plan and conducted a general discussion of it.

Officers elected at the meeting were the following:

President and Alternate Delegate—Dr. L. E. Nystrum, Medford

Secretary—Dr. D. M. Norton, Medford

Shawano—Waupaca

A joint dinner meeting of the Shawano County Medical Society and the Waupaca County Medical Society was held Tuesday evening, June 22, at the Elwood Hotel, New London. Dr. Henry H. Christofferson, Colby, president of the State Board of Medical Examiners, addressed the group on the enforcement of the Medical Practice Act in Wisconsin. A film on "Peptic Ulcer" was shown.

Trempealeau—Jackson—Buffalo

Dr. Charles H. Slocumb, Rochester, Minnesota, was guest speaker on July 15 at a dinner meeting of the Trempealeau–Jackson–Buffalo County Medical Society held at the Arcadia Hotel, Arcadia. The topic of his discussion was "The Treatment of Arthritis."

Second Councilor District

The annual meeting of the Second Councilor District of the State Medical Society of Wisconsin was held at the Lake Geneva Hotel, Lake Geneva, on Wednesday, August 4, with the Walworth County Medical Society and Auxiliary as hosts. The following program was presented:

10:00 a. m.—"Ectopic Pregnancy," Frederick Falls, M. D., Chicago

11:00 a. m.—"Tuberculosis in Children," Eugene McEnery, M. D., Chicago

11:30 a. m.—"Modern Treatment: Carcinoma of the Prostate," Harry Culver, M. D., Chicago

12:00 noon—"Refrigeration Anesthesia," Harry Mock, M. D., Chicago

1:00 p. m.—Luncheon

2:00 p. m.—Golf, boating, swimming, trip around Lake Geneva

7:00 p. m.—Dinner

Speakers: Mr. C. H. Crownhart, Madison, Secretary of the State Medical Society

Russell M. Kurten, M. D., Racine, President of the State Medical Society

SOCIETY RECORDS

New Members

Mary Broadbent, Milwaukee.
Katherine H. Baird, Milwaukee.
A. C. Bachus, Ripon.
Esther Goldberger, Wauwatosa.
H. F. Bischof, Richland Center.
R. P. Fruehauf, Superior.

Changes in Address

W. S. Marshall, Appleton, to 1407 Springhill Avenue, Mobile, Alabama.

C. W. Hughes, Palisades, California, to Veterans Administration, Alexandria, Louisiana.

E. T. Hougan, Oosterburg, to 1607 Union Avenue, Sheboygan.

D. R. Notbohm, White Lake, to 105 Clarence Street, Fort Atkinson.

O. R. McMurry, Eagle River, to Greendale.

Elmer Schmidt, Wauwatosa, to 138½ Front Street, Beaver Dam.

A. S. White, Baraboo, to 1105 College Avenue, Racine.

H. C. Marsh, Crandon, to % Ball Memorial Hospital, Muncie, Indiana.

C. R. Brillman, Cobb, to 1414 North 12th Street, Milwaukee.

Haldor Barnes, Manitowoc, to 2425 Robinwood Avenue, Toledo, Ohio.

BIRTHS

A daughter, Margaret Elaine, to Dr. and Mrs. Samuel R. Beatty, Oshkosh, on July 10.

A daughter to Dr. and Mrs. Herbert Sydow, Waukesha, on June 19.

Twin daughters, Katherine and Barbara, to Dr. and Mrs. Edward J. Schelble, Milwaukee, on June 28.

A daughter to Lieutenant and Mrs. Russell Jackson. Madison, on July 8.

DEATHS

Dr. Lambert J. Hargarten, 71, Milwaukee, died Monday, June 21, following an illness of six months.

He came to America in 1888 from Germany, his birthplace. He settled in Iowa, where he was graduated from the Woodbine Normal School and where he later taught. In 1904, he was graduated from the Wisconsin College of Physicians and Surgeons, Milwaukee. From the time of his graduation until his death he was a practicing physician and surgeon in Milwaukee.

He is survived by his widow, three daughters, and four sons.

Dr. James W. Doughty, for more than twenty years a practicing physician at Delavan, died Sunday, July 11, in San Mateo, California, where he had been during the last nineteen months in an endeavor to regain his health. He had been critically ill for several weeks.

A graduate of the University of Illinois College of Medicine, Chicago, he started his practice in Delavan after World War I. He was a member of the Walworth County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

His widow and one sister survive him.

Dr. Raymond W. Andrae, 62, Plainfield, died Wednesday morning, June 2, at a Madison hospital.

He was a graduate of Milwaukee Medical College. With the exception of a short time which he spent in further medical study and in practice at Stevens Point he carried on his entire career at Plainfield as a physician and surgeon. His retirement a few years ago was necessitated by a stroke.

Dr. Andrae was a member of the Portage County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

His widow survives him.

News of the Neighbors

Voluntary or Coercive? Choose!

"The Commission on Industrial Health and Hygiene is gratified that 70 per cent of the component societies held industrial health meetings as requested. The work must not stop there! Trade and labor organizations must be contacted, and a definite drive instituted to bring adequate medical service into all industry, especially into small plants. Allegheny, Lycoming, and Philadelphia counties are leading the State to the extent that, in all three, physicians have had instruction in the rudiments of industrial health. But, this has built a backlog of those who have not as yet been placed in industry.

"A bottleneck has been developed. It is not of our making, but we are trying to break it. The bottleneck is the laissez-faire attitude of the small employer toward proper health maintenance inside his plant. He thinks he can't afford this service. He can be shown that he can't afford to be without it. In a short time the county societies will have these arguments in black and white.

"But we cannot suddenly service all the industries in this State. We must approach the problem in definite, well-planned steps. For this year your commission suggests service for only one group—those plants employing 250 or more people. We take our cue from England. The British government has passed a law *forcing* all such employers to maintain an 'in-plant' medical service. Do we Americans need to wait for such a jolt? Can't we do voluntarily what others must be forced to do by law? The answer will be forthcoming by 1944. Our goal is a medical service in all Pennsylvania plants of 250 or more employees. Let's make it by next New Year's Day!" Editorial from *The Pennsylvania Medical Journal*, May, 1943.

Incidentally

"With the ever increasing number of problems calling for solution by the medical profession, can medical societies afford not to continue to hold regular, frequent meetings?—What other source affords such opportunity for the exchange of ideas and for

concerted action?—A fundamental of Democracy must necessarily be intelligent action on the part of its adherents." From *The Journal of the Missouri State Medical Association,* June, 1943.

Surgical Care, Inc.

"It is understood that Surgical Care, Inc., of Kansas City is now under way.—This is a prepaid surgical care plan operating on a contractual basis.—Surgical Care, Inc., was organized late in 1942 with the approval of the Jackson and Wyandotte county medical societies.—The management of the business of the corporation is charged to a board of directors consisting of fifteen members, all of whom are duly licensed physicians in the private practice of medicine and participating members of the corporation." From *The Journal of the Missouri State Medical Association,* July, 1943.

Unfair Criticism

"At a legislative committee hearing relating to formation of cooperatives providing medical and hospital care, Mr. Lewis Roherty of Madison, representing the Wisconsin Farm Bureau Federation, made the following statement. 'We feel that there is an effort on the part of the organizations such as the Medical Association to try to prevent people from improving their own conditions and have taken upon themselves more than any law should permit.' The statement referring to the Medical Association gives us little concern as they are amply able to refute the charges, though it does show ingratitude for the many health measures conceived and accomplished by that organization. The main point that we wish to call attention to is the fact we are about the most similar organization to qualify as 'such organizations.' For years the Wisconsin State Dental Society has attempted to promote a State wide Dental Health Program, with its motif being prevention. Every component society and many individual dentists have worked unceasingly to try to interest the public in dental health. While it is true that there is an element of expense in prevention, it is nominal compared with the cost of restoring a neglected and devastated mouth. Dentists employ every ruse their ingenuity allows to forestall the tragedy of dental disease, and yet a great percentage of people employ the services of a dentist only when they are driven to it by actual pain or from a cosmetic urge.

"The indifference and lack of response to education has been most discouraging. County boards and school commissions in the most part have resisted, or been passive to our efforts to a degree that is difficult to understand. Much of the high cost of dentistry can be avoided if prevention programs are carried out as outlined. What more can dentistry do? We would like Mr. Roherty to point out to us how we might better help people to improve their condition in so far as dentistry is concerned." An editorial from *The Journal of the Wisconsin State Dental Society,* July–August, 1943.

Extra Ration Points For Special Diets

"A special committee in Madison, Wisconsin, with Elmer L. Sevringhaus, M. D., as Chairman, prepared a brochure 'Extra Ration Points for Special Diets.' This brochure has been reviewed by several of our members. They have expressed approval of the information compiled and have found it helpful in determining ration requirements for their patients under special diets for different types of illness.

"The brochure was printed by *The Wisconsin Medical Journal* and the cost for additional copies is 10¢ each. You may examine copies of the brochure either in the Library or the Executive Office. If you desire copies obtained for your use, we will be glad to cooperate in requesting them from the publisher." By W. H. Bartleson, executive secretary of the Jackson County Medical Society, in its *Weekly Bulletin,* June 19, 1943, published at Kansas City, Missouri.

The Technic of Home Canning

"Very welcome is this article (Dorothy L. Hussemann, Madison, in *Wisconsin Medical Journal,* May) showing that the editor of one of our best State journals recognizes the importance of the family doctor as an adviser in all matters of health. Very timely it is, and its pith is passed on to our readers to help them to advise in their localities." From *Southern Medicine & Surgery,* June, 1943.

THE PRESS

Doctor Faces Second Charge of Abortion

"Milwaukee—(U.P.)—Dr. Edmund W. Timm, 68, was named in a new warrant and two women also were charged with offenses today by authorities investigating the abortion death June 15 of Hazel Williamson, 34, Waunakee.

"Timm, at liberty under $5,000 awaiting hearing June 29, on a charge of second degree manslaughter, was charged in a new warrant with performing an illegal operation upon a 27-year-old woman on June 9.

"Mrs. Christine Schlabach, operator of a rooming house where Miss Williamson died, was charged with being an accessory after the fact in the Williamson case, and with advising illegal operation upon the 27-year-old woman. Investigators found Mrs. Schlabach's rooming house equipped with the facilities of a 'lying-in hospital,' according to Deputy Dist. Atty. A. J. Beyer, who obtained the warrants.

"The other woman charged with similar offenses is Mrs. Emma Lee, 71, Racine, former housekeeper at the Schlabach rooming house who left the day Miss Williamson came there, according to Beyer. Mrs. Lee was charged with performing an abortion upon a 28-year-old woman on June 7." From the *Wisconsin State Journal,* Madison, June 21, 1943.

Misuse of Title

"Fred Neukom, 63, of Winona, Minnesota, Thursday night was freed of a charge of practicing medicine without a state license and was found guilty of improperly using the title 'doctor' by a municipal court jury.

"The charge under which Neukom was freed was brought as the result of a complaint signed by D. Waldo Hutton, Milwaukee, investigator for the state board of medical examiners. Hutton testified during the trial that he had been treated by Neukom on Jan. 27, 1943." From the *Racine Journal Times*, June 4, 1943.

Trade News

Second Army–Navy Production Award Given to General Electric

Announcement of a second award for excellence of war production to the General Electric X-Ray Corporation, Chicago, was received by the company July 17 in a letter from Robert P. Patterson, Under Secretary of War. This award adds a white star to the Army–Navy "E" flag which has flown over the company's plant since the coveted industrial prize was first presented as of January 26 of this year.

Schering Corporation Expands Its Quarters

In an expansion move dictated by the greatly augmented demand for its pharmaceutical and hormone products by Government and Lend-Lease agencies, as well as by civilian physicians and hospitals, Schering Corporation has transferred its General and Administrative offices from their former location in its Bloomfield factory at 86 Orange Street to The Bloomfield Bank and Trust Company building at 2 Broad Street, Bloomfield, New Jersey. The entire sixth and seventh floors in this office building will be occupied by the corporation executives and the personnel of the Medical Research, Professional Service, Accounting, Domestic and Foreign Sales, Advertising and General Office staffs. Approximately 125 persons are being established in these new quarters.

In reviewing the factors which necessitated this change in location, William J. Hagenah, Chairman of the Board of Directors, explained that by moving the executive offices at this time, additional factory space will be made available for the needs of the Production Department which is now operating at full force. Schering Corporation also has laboratories and a factory in Union, New Jersey.

Riggs Optical Company Tells Shortage Story in an Interesting Style

The latest issue of the "Riggs Reporter," published by Riggs Optical Company and released in July, contains a story on shortage which is presented in an unusual manner.

Using Rationville as a theme, the cover shows an illustration of a roadside sign which reads "Rationville U. S. A." In the background a typical American community is depicted, while the remaining space on the cover is devoted to the Rationville story. The inside spread shows the outline of the map of the United States which contains within its boundaries newspaper clippings pertaining to stories on shortages. The folder is striking in design and is printed in red and blue.

Change in Casec Measurements

Casec now measures 6 *packed* level tablespoonfuls instead of 12 level tablespoonfuls, as formerly, so that directions to the patient should be amended accordingly. Casec is indicated in colic and loose stools in breast-fed infants, and in fermentative diarrhea, malnutrition, celiac disease and for premature infants. Mead Johnson & Company, Evansville, Indiana, U. S. A.

American Home Products Corporation Expands for Third Time This Year

Alvin G. Brush, chairman of American Home Products Corporation, manufacturer of drugs, foods and household products, today announced the corporation's third expansion step this year in the field of biologic products through the acquisition, by merger, of The Gilliland Laboratories, Inc., of Marietta, Pennsylvania, producer and distributor of a wide line of serums, vaccines and antitoxins.

Gilliland Laboratories is the successor to H. M. Alexander and Company. Founded in 1882, Alexander was one of the oldest biologic laboratories in the United States and was the first producer of smallpox vaccine on a commercial scale in the country.

Gilliland Laboratories has become a wholly-owned subsidiary of American Home Products. Its management, headed by Dr. E. K. Tingley as president, and its personnel and policies will remain unchanged, Mr. Brush stated, but its production and sales will round out the lines of pharmaceuticals and biologic products, now marketed by John Wyeth & Brother, Inc., Reichel Laboratories, Inc., and Ayerst, McKenna & Harrison, American Home Products' major subsidiaries in these fields.

The Journal Bookshelf

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Psychosomatic Medicine. The Clinical Application of Psychopathology to General Medical Problems. By Edward Weiss, M. D., professor of clinical medicine, Temple University Medical School, Philadelphia; and O. Spurgeon English, M. D., professor of psychiatry, Temple University Medical School, Philadelphia. Cloth. Price, $8. Pp. 687. Philadelphia: W. B. Saunders Company, 1943.

This work fills a long felt need and comes at a time when the spectacle of thousands of psychoneurotics, brought into relief by war, again rears its ugly head. Having learned many lessons from the experiences of World War I, government agencies and military authorities feel keenly the responsibility of eliminating men from military service who are unfit because of poor psychic equipment. These men are being discharged and are returning to their communities in need of help to overcome their inadequacy. The services of psychiatrists are unavailable for most of these men, who will come to the attention of the family physician.

"Psychosomatic Medicine" focuses attention on the "whole patient"—not just on his refractory organs. The first two chapters are concerned with general concepts of psychosomatic medicine and psychopathology and serve to orient the student or the physician to his task. Then follow chapters dealing with organs and systems in which the relationship of emotions and the "life situation" to a disordered cardiovascular system, or to an irritable colon, for example, is analyzed. The authors deal not only with the psychogenic somatic disorders, but they also show the effect of organic disease upon the emotionally labile personality. Special topics such as the relationship of the emotions to allergy and military medicine are discussed. The last three chapters deal with principles and practice of psychotherapy.

The authors acknowledge their indebtedness to Freud and his followers, yet in their work they have avoided the familiar Freudian landmarks of infantile sexuality, castration complexes, anal erotic fixations, oedipus complex, etc. Psychosomatic medicine, a new descriptive term, represents a compromise by the psychoanalytic school, which finding its ideology and discipline too rigid, unintelligible and time consuming to be generally useful, has yielded, as could be anticipated, to pressure from without. But the technic employed, as has been stated by Weiss and English, is as old as the art of healing itself. One does not have to be familiar with Freudian doctrine to understand the psychologic approach made by the authors in "Psychosomatic Medicine." It is a timely and useful text. M. G. M.

The 1942 Year Book of Industrial and Orthopedic Surgery. Edited by Charles F. Bainter, M. D., orthopedic surgeon to the Massachusetts Women's Hospital and Beth Israel Hospital, Boston. Cloth. Price, $3. Pp. 424, illustrated. Chicago: Year Book Publishers, 1942.

In this year book for 1942, Dr. Painter has culled the literature for the preceding year.

In the opinion of the reviewer he has done a good job.

For those interested in the subject, the book is worth its purchase price. R. E. B.

Military Surgical Manuals. Volume IV. Prepared and edited by the subcommittee on orthopedic surgery of the committee on surgery of the division of medical sciences of the National Research Council. Cloth. Price, $3. Pp. 306, with 79 illustrations. Philadelphia: W. B. Saunders Company, 1942.

This book, dealing with orthopedic subjects, was written to answer the need for a clear concise presentation of some of the more difficult orthopedic problems such as are faced by the medical men in the armed services of this country. It is a small volume packed with the important, pertinent facts which are essential for the best treatment of these problems.

It emphasizes the tried and proven methods in vogue at this time and provides as well a thorough discussion of some of the newer methods which are aided or made possible by the use of sulfonamides. The authors are all nationally recognized orthopedic surgeons whose wide experience and soundness of judgment give their contributions to this book definite authority. The clarity, briefness, and thoroughness with which the various sections are presented recommend this book also to the use of the general practitioner.

Section I deals with ununited fractures. This section is commendable for its accurate presentation of preoperative, operative, and postoperative care required for the proper treatment of this condition. Following this there is a presentation of the local anatomic treatment of ununited fractures in various locations.

Section II, dealing with injuries of the spinal column, is one of the outstanding portions of this book. It presents a complete discussion, the method of examination, handling and care of patients suffering from fractures, dislocations or fractured dislocations involving a spinal column. Injuries of this site are such that transportation of the patient to a

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locality where complete treatment can be carried out is dangerous because of the close proximity and vulnerability of the spinal cord. Demonstration of proper handling and immobilization of these conditions is well covered by a considerable number of illustrations to emphasize correct procedure.

Section III deals with compound fractures. This section is written chiefly from a military standpoint emphasizing the difference in treatment of compound fractures which result from relatively slow-moving shell fragments as contrasted with those resulting from high-speed bullets. The importance of the use of sulfonamide drugs and their role in the treatment of gas gangrene is well described. This section is well recommended to the general practitioner who must treat compound fractures in localities where all the expensive facilities are not available.

Section IV is concerned with the problem of osteomyelitis. The subject is thoroughly discussed in its various phases and has an excellent section on acute hematogenous osteomyelitis as it is seen in children and adolescents. This is in contrast to its behaviour in adults. Here again, the book serves the general practitioner well in emphasizing the clinical picture and importance of early recognition of acute osteomyelitis. The treatment of chronic osteomyelitis is well discussed. The indication for and against surgical treatment of chronic osteomyelitis is nicely presented. This section is well correlated with the section on compound fractures which result from shot wounds. The difficulty of treatment of this condition strongly recommends the proper treatment of compound fractures, for it is from the latter group that a great number of cases of osteomyelitis will develop unless properly treated.

Separately and collectively the sections of this book provide an excellent discussion of some of the problems dealing with orthopedic subjects. The reasons for writing this book are indicated by the information contained between its covers. It serves the purpose for which it was written. F. G. G.

Outline of Roentgen Diagnosis. An Orientation in the Basic Principles of Diagnosis by the Roentgen Method. By Leo G. Rigler, B. S., M. B., M. D., professor of radiology, University of Minnesota, Minneapolis, Minnesota. Ed. 2. Cloth. Price $6.50. Pp. 196, with 254 illustrations shown in 227 figures, presented in drawings and reproductions of roentgenograms. Philadelphia: J. B. Lippincott Company, April, 1943.

This text presents the elementary facts of roentgen diagnosis in outline form and is intended primarily for the student and teacher. The second edition follows the style and format of the first but has been brought up to date by the addition of pertinent subject matter. The book was not intended as a reference work and will have little appeal to those who wish a detailed coverage of the subject of roentgen diagnosis. Discussions of roentgen findings are brief and, in the main, given in outline form. Paragraphs on the value of the roentgen examination are included for each of the various lesions and diseases discussed. The illustrations, of which there are 227, are grouped together in the form of a pictorial Atlas at the end of the book. They are of good quality, adequately labeled and of sufficient number for a book of this type. No bibliography is appended except for a short list of standard reference works. The index is adequate. This book can be recommended for use as a text in the teaching of undergraduate students and for those who wish a brief synopsis of the subject. L. W. P.

Fundamentals of Immunology. By William C. Boyd, Ph. D., associate professor of biochemistry, Boston University School of Medicine; associate member, Evans Memorial, Massachusetts Memorial Hospitals, Boston. Cloth. Price, $5.50. Pp. 446, with 45 illustrations. New York: Interscience Publishers, Inc., 1943.

"Fundamentals of Immunology" gives an excellent presentation of antigens, antibodies and the serologic reactions, abreast of the recent advances in immunochemistry. The diverse technics of serology and immunology are presented in the final chapter, which might well serve for the selection of laboratory exercises in a comprehensive course. In the reviewer's opinion, the book would be improved for use by medical or other beginning students by a greater emphasis upon the mechanisms of immunity, specific and nonspecific; by a more sustained consideration of phagocytosis, antibacterial and antitoxic immunity. "Fundamentals of Immunology" is an excellent and timely book, a distinct contribution to the field. F. E. H.

Diseases of the Breast. Diseases, pathology, treatment. By Charles F. Geschickter, M. A., M. D., Lieut. Commander, Medical Corps, United States Naval Reserve; director of the Francis P. Garvan Cancer Research Laboratory; pathologist, St. Agnes Hospital, Baltimore. Cloth. Price, $10. Pp. 829, with 593 illustrations. Philadelphia: J. B. Lippincott Company, January, 1943.

Geschickter's new edition of "Diseases of the Breast" is one to which both internists and surgeons alike should refer for a complete study of the pathology of the human breast. The study is complete, well written, and contains much recent experimen-

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tal and clinical work which has added considerable valuable information to this complicated subject. Unprejudiced information as to therapy in such conditions as chronic mastitis, intraductal papillomas, and carcinoma is particularly good. The weak point, if one can find such, is perhaps in the description of the histopathology. Comparative statistics in the various diseases are of great value, particularly in studying the diagnosis and results of therapy. O. V. H.

Dictionary of Bio-Chemistry and Related Subjects. Edited by William Marias Malisoff, professor of biochemistry at the Polytechnic Institute of Brooklyn. Cloth. Price, $7.50. Pp. 579. New York: Philosophical Library, 1943.

This book represents a combination of a scientific dictionary and an encyclopedia. The encyclopedic portion is on the whole fairly well done since it includes reviews by several outstanding investigators. The reviews for the most part are condensations of review papers already published.

The dictionary portion is in reality a somewhat modernized version of a medical dictionary, although many obsolete terms are retained. The book suffers by comparison, however, due to the many inadequate and far too many inaccurate definitions. The use of literature references in certain instances is highly commendable. The need for including a few anatomic terms, in some instances badly defined (see, e.g. abdomen), is not apparent. The attempt to discuss briefly clinical aspects of disease entities has resulted in many statements which are at best debatable and certainly out of place in a dictionary of this type.

The definitions of terms dealing with intermediary metabolism lack clarity, and many are inaccurate. For example, acetaldehyde reductase is said to be "similar in structure to the yellow respiratory enzyme." As a matter of fact, this enzyme, more familiarly known as alcohol dehydrogenase, has as a prosthetic group diphosphopyridinenucleotide. Pyruvic oxidase is defined as a "thiaminoprotein of the *avitaminous* brain . . ." Many other similar errors are present.

The discussion of acid-base balance includes such inaccuracies as the statement that the kidney converts urea to ammonia in order to conserve base. Typographic errors are frequent. The arrangement of the text varies from page to page. Thus on some pages columns read from top to bottom, on others, they read to about halfway down the page and then continue from the top of the next column. The book is poorly constructed both as to choice of paper and the durability of the binding.

In the opinion of the reviewer, it is doubtful that in its present form this book will be of much value to the reader of biochemical literature, for whom, according to the editor-in-chief, it is primarily intended. P. P. C.

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The Medical Clinics of North America. Volume XXVII, Number 2. Symposium on Nutrition. 33 contributors. Cloth. Price, $16 per clinic year. Pp. 320, illustrated. Philadelphia: W. B. Saunders Company, March, 1943.

This is an excellent series of condensed reviews showing the current point of view of the different authors involved in the symposium. As usual, there is more attention to vitamins than any other one aspect of nutrition, but this symposium is genuinely comprehensive in its coverage of nutrients and chemical problems and its furnishing of the good bibliography to stimulate the reading of anyone who wants to pursue any given topic further. It is a volume for the general physician, not for the investigator in the field. E. L. S.

The Medical Clinics of North America. New York Number. Volume XXVII, Number 3. Symposium on Infectious and Tropical Diseases. 19 contributors. Cloth. Price, $16 per clinic year. Pp. 881, illustrated. Philadelphia: W. B. Saunders Company, May, 1943.

This book is arranged in a manner similar to its recent predecessors. It is timely in that it is a symposium on infections and tropical diseases. Twenty diseases are ably discussed by writers who are authorities in the respective fields.

"The Medical Clinics" are well known to many physicians and to them they need no recommendation. The present volume maintains the high standards of those previously published. It will be found to be unusually valuable because it discusses many diseases with which the Wisconsin physician has had little contact to date, although the possibility of increased prevalence of these entities in the future seems strong. O. O. M.

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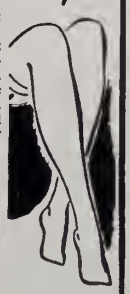

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By Warren H. Cole, M. D.

THE NEW PROPHYLACTIC MEASURES IN TETANUS
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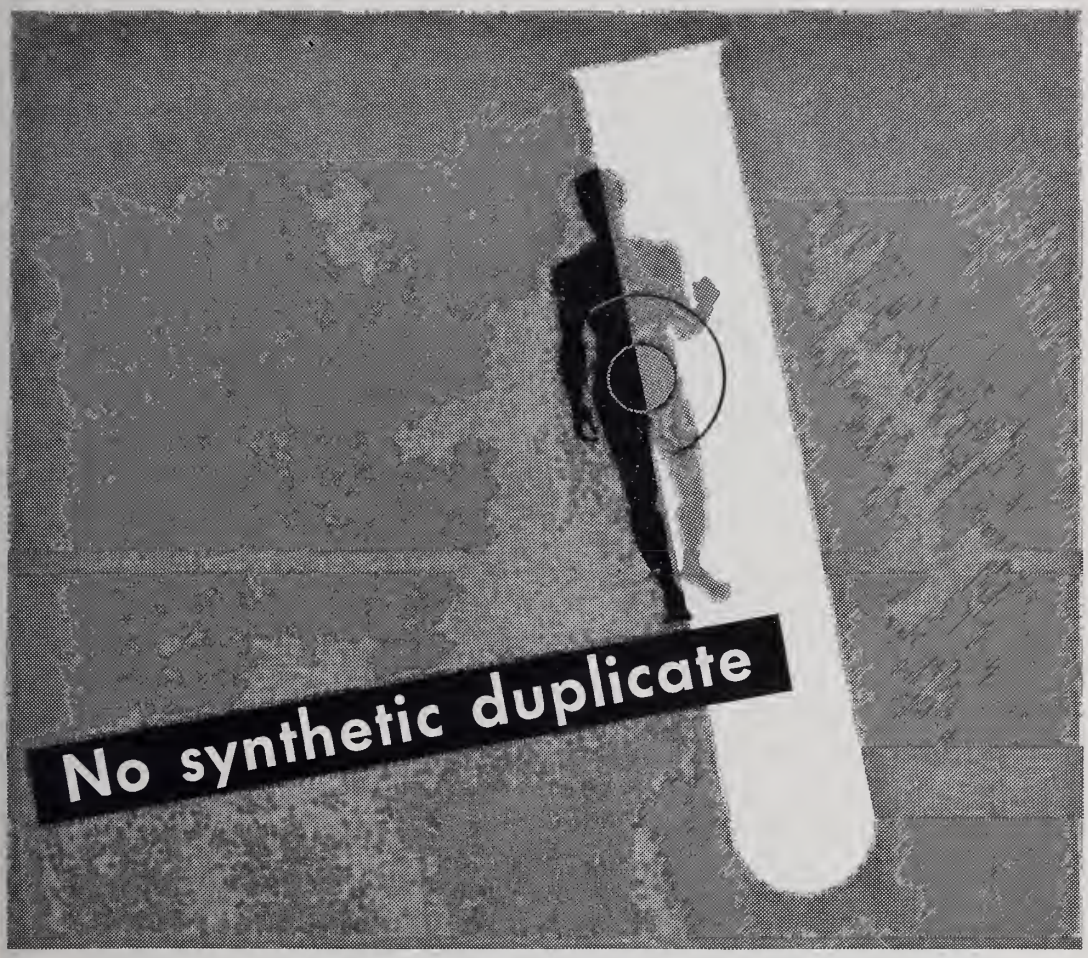

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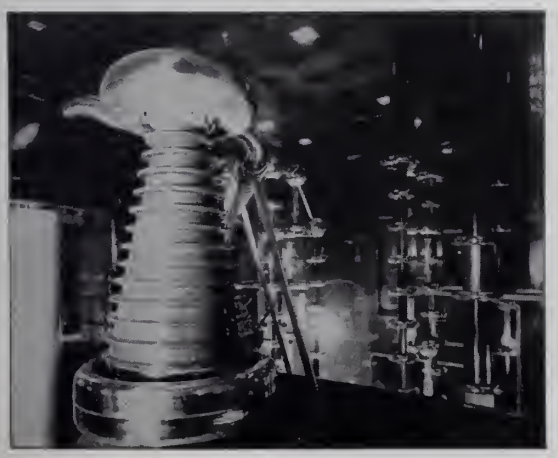

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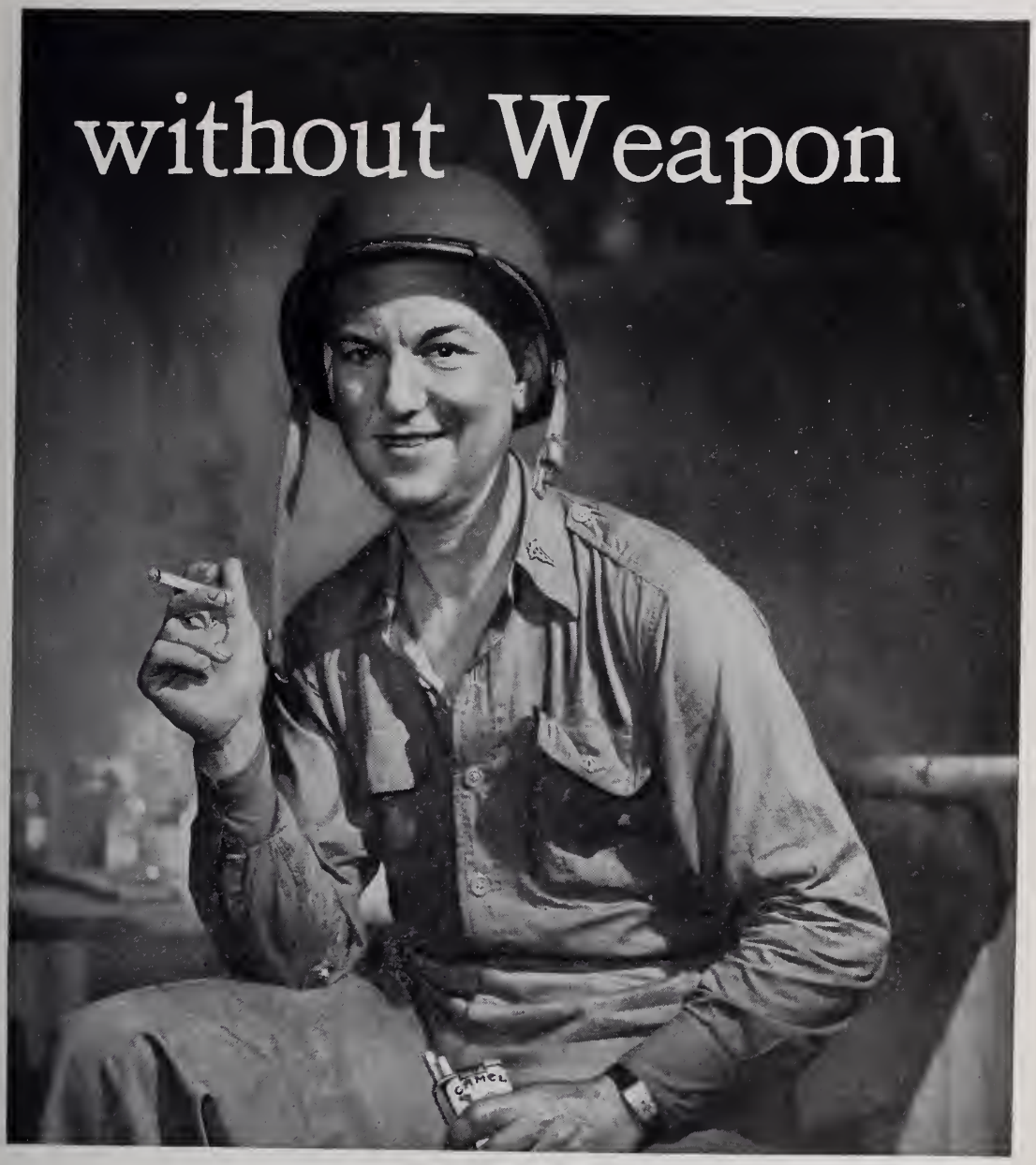

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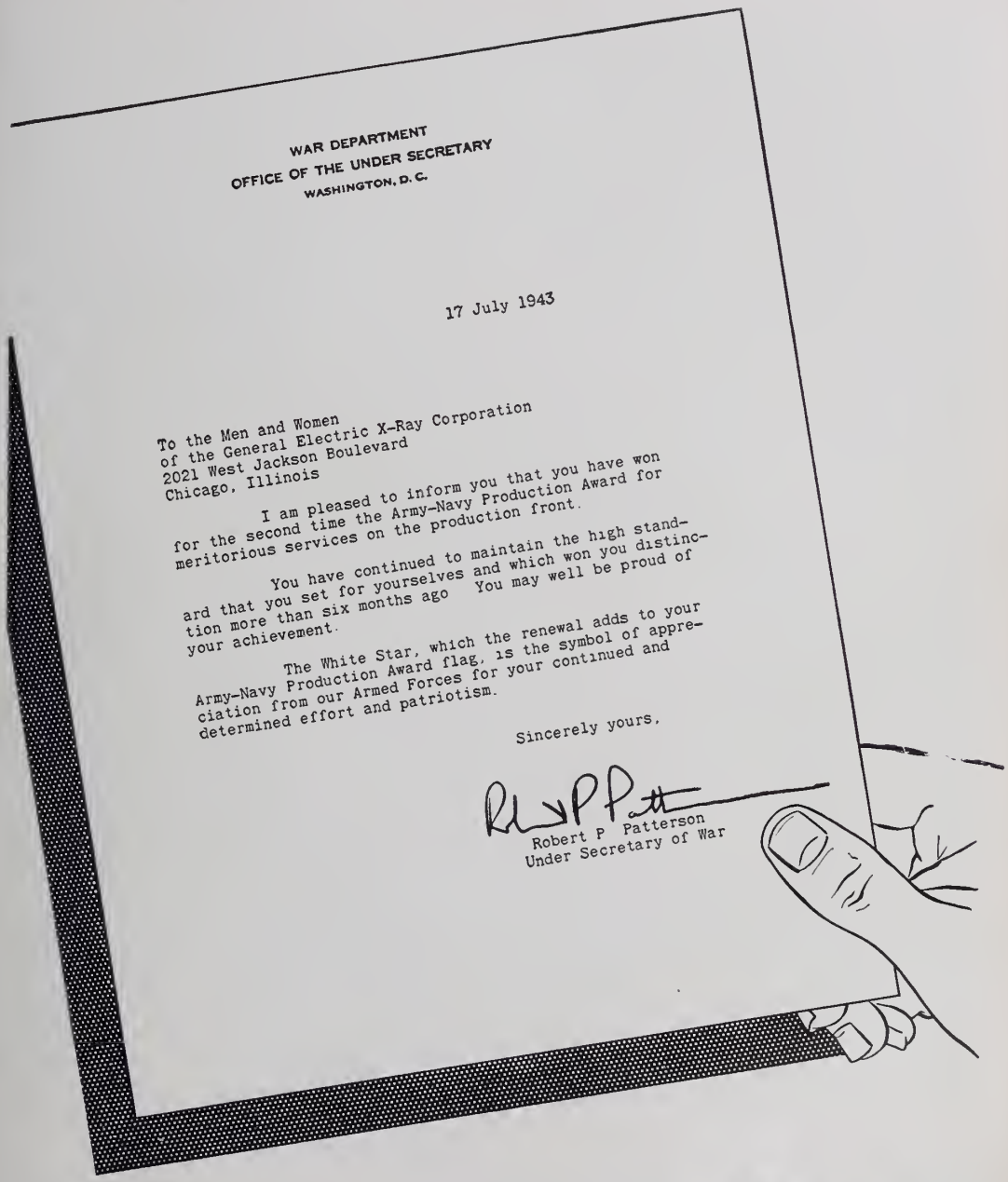

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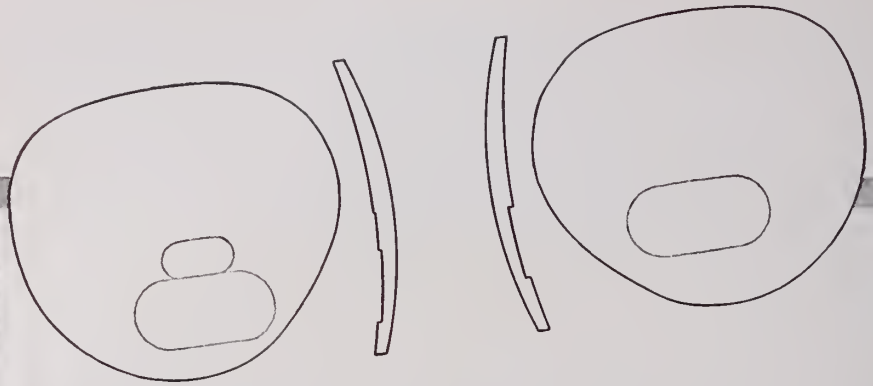

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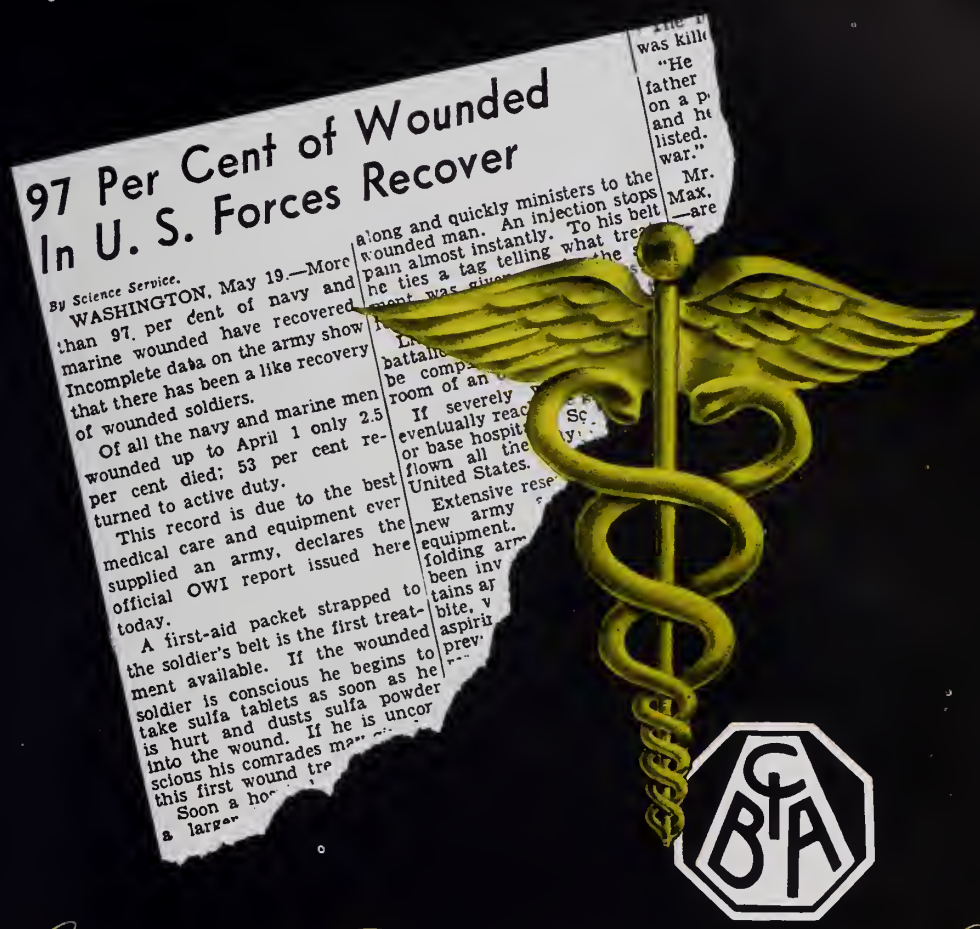

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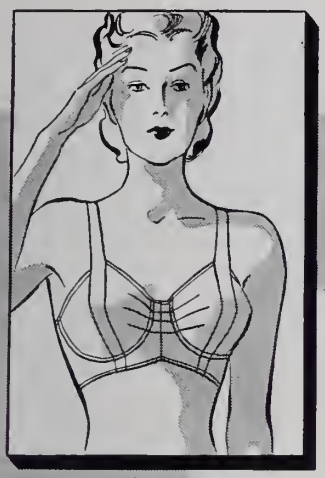

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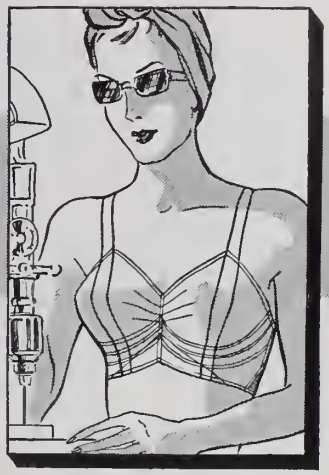

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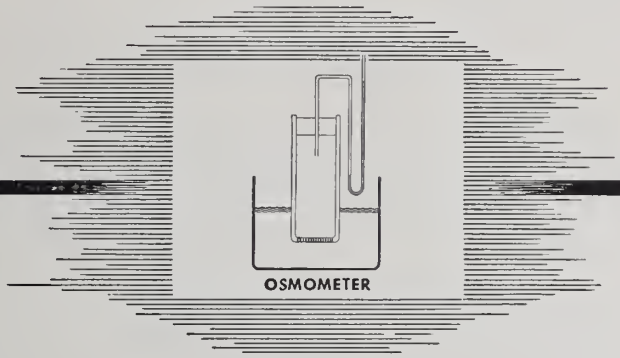

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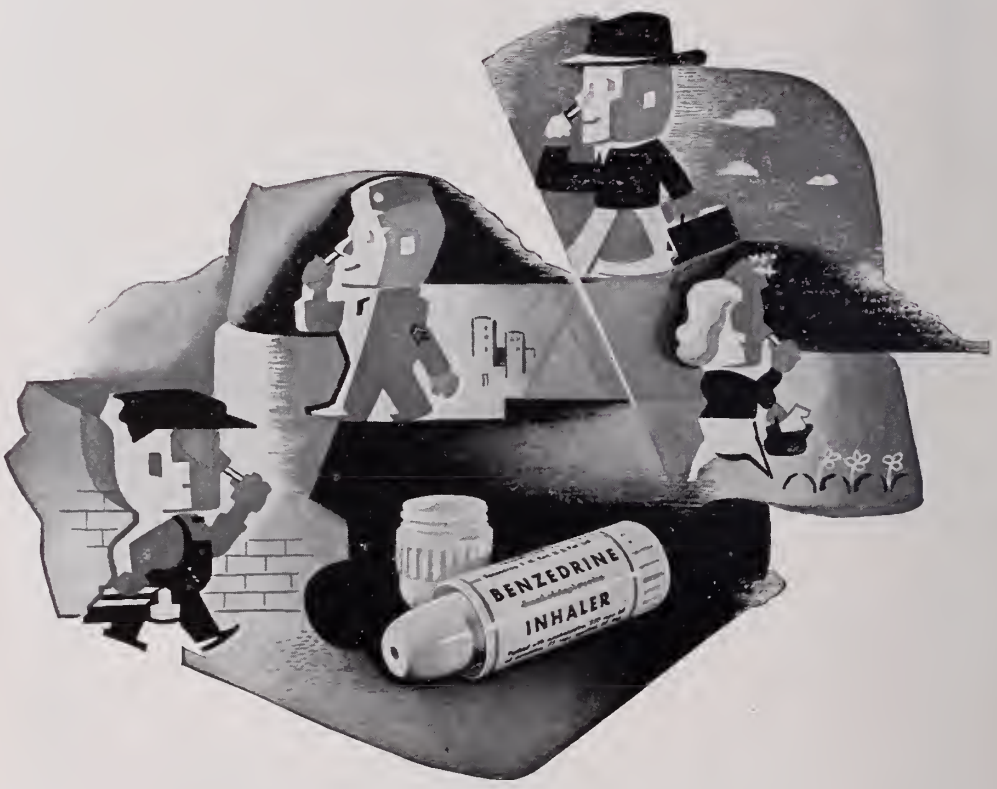

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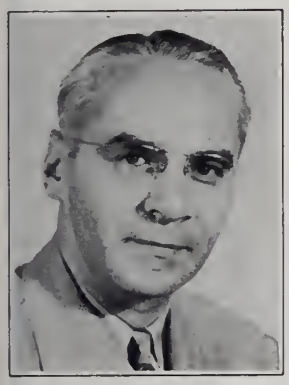
Trichinosis Epidemic in Rock County

By THORN L. VOGEL, M. D.
Milton Junction



THORN L. VOGEL

Dr. Vogel received his M. D. degree at the University of Wisconsin Medical School in 1929.

ON THE sixth day of May, 1943, a white man was admitted to Mercy Hospital, Janesville, Wisconsin, complaining of muscle pain, swollen jaws, and puffy eyes following a gastrointestinal upset. A routine blood smear showed eosinophilia, and a tentative diagnosis of trichinosis was made. It was soon discovered that many members of the neighboring community were afflicted with similar complaints. The various diagnoses made were gastrointestinal catarrh, bronchial or virus pneumonia, food poisoning, and colitis. Blood smears obtained on these patients revealed eosinophilia, and a more detailed examination was made whenever possible.

The epidemic involved 28 patients comprising thirteen families. Three of the patients were not seen by a doctor, and the information was gathered by questionnaires or from other members of the family. Most of the patients were confined to their homes and were seen only three or four times; 3 were hospitalized and were studied in much greater detail.

Criteria for a Positive Diagnosis

The diagnosis of trichinosis may be difficult but, if suspected, can be fairly simple. Our criteria for a positive diagnosis were as follows:

(1) A history of eating summer sausage obtained from a local butcher and followed in a week or so by an illness.

The sausage was made from contaminated pork probably (but not proved) obtained from black market animals, and, since summer sausage does not undergo either cooking or refrigeration, the encysted larvae were not killed. No samples of the contaminated supply were available at the time the epidemic was diagnosed, and later samples from the same shop were negative for the worm when tested at the State Laboratory of Hygiene. Two of the patients had eaten sausage made from a home cured supply of pork.

(2) A history of typical signs and symptoms which ran a fairly typical course.

(3) Eosinophilia: Present in all cases.

(4) Skin tests: In some cases these were done on only one member of an afflicted family if there was no question that they all were suffering from the same condition.

(5) Special laboratory procedures: These were done on the hospitalized patients and included muscle biopsies and spinal punctures as well as a more detailed study of the course of the disease.

Table 2 showing the general considerations and the methods of diagnosis needs little explanation. Age and sex seemingly

made little difference as to either type or severity of the illness. However, despite comparable severity of acute symptoms, the youngest patient seemingly recovered more rapidly than the patients in the older age groups.

The patients were farmers, laborers, or small businessmen. The skin test was made by the intradermal injection of 0.1 cc. of a 1/10,000 solution of the antigen. The reaction was graded from a negative to a 4 plus response, depending on the size of the wheel and the area of the erythema. The tests were made during a period from one to four weeks after symptoms had appeared. One patient tested negative during the first week and 3 plus three weeks later. Of the four negatives, one was a hospital patient who, when tested during the second and again during the third week of his illness, was observed for both the immediate and the delayed type of reaction and gave neither. The larvae were later found by muscle biopsy. One patient was negative three weeks after developing symptoms, and the other two negative tests were made during the first week of illness. Since the injection site was examined for only the immediate type of reaction, there is a possibility that some or all of the negative tests may have had a delayed reaction.[1] All 4 negative-testing patients had high blood eosinophilia.

Muscle biopsies were taken of the 3 hospitalized cases. Two were from the gastrocnemius, one from the trapezius in the midscapular region, and one from the biceps femoris. The latter locations were chosen as most likely, since the most muscle pain was elicited here. The negative biopsy was taken from the gastrocnemius of the patient with the 4 plus skin reaction and the most severe case seen. Another biopsy taken a week later from the biceps femoris was positive. All biopsies were taken during the third or fourth week and showed the larvae not encysted.

Comparative Symptomatology

The symptomatology observed varied from case to case but all had some of the classic symptoms in common. The presenting symptom in 10 of the patients (table 2) was gastrointestinal. If gastrointestinal symptoms were present, they were found, as would be expected, during the first week.[2] However, in a few cases, diarrhea continued for as long as ten to fifteen days. It has been speculated that severe diarrhea would lessen the severity of the following developing symptoms because the intestinal tract would be cleaned of the worms. We found this to be only partially true. Of the 12 patients having diarrhea, 3 were classified as being severely ill, the others moderately ill. There were 8 cases with mild constipation, which, if the corollary is true, should be marked by an increase in the severity of the disease. Two of these were severely ill, 3 moderately, and 3 mildly ill. It was felt that the diarrhea or constipation was only a manifestation of intestinal irritation and did not influence greatly the severity of developing symptoms.

Of the 10 patients with swollen eyes as the first symptom, 4 (all in one family) noticed their complaint the evening of the day on which the sausage was eaten, and no history of previous ingestion of pork could be obtained. These 4 patients also complained of mild constipation. Three others (all in one family) had eye edema three days after ingestion, and another family of four had eye edema three weeks after eating sausage. The patient with headache as the presenting symptom had been eating home cured pork (one of 2 cases traced to this and not to purchased sausage) for a variable period of time and did not associate the illness with any particular meal.

Nausea and vomiting were present in 3 patients and were mild and of short duration. Anorexia was noticed generally early in the disease, but the appetite usually improved within three to five days. The occurrence of chills was felt to be associated with the appearance of larvae in the blood stream, as the chills occurred after gastrointestinal symptoms and before or with muscle aching and other signs of peripheral dissemination. They were followed by fever and occurred over a period of from three to seven days. One patient had a severe chill every day at 5:00 p.m. for a period of one week.

TABLE 1

Total Cases	Families	Age	Male	Female	Ate Sausage	Present Clinical Picture	Blood Count: Not Done	Blood Count: Eosinophilia	Skin Test: Not Done	Skin Test: Neg.	Skin Test: Pos.	Biopsy: Done	Biopsy: Pos.	Deaths
28	13	5–74	15	13	28	28	7	21	12	3	13	4	3	0

TABLE 2.—SYMPTOMS

Cases	Gastrointestinal							Muscle		Eye						
Questioned	Diarrhea	Constip.	Nausea & Vomiting	Cramps	None	Chills	Fever	Ache	Weakness	Edemm	Injection	Photophobia	Lacrimation	Rash	Cough	Headache
26	12	8	14	4	2	19	24	26	26	22	17	9	2	3	9	17
Presenting Symptom	5			3		2				13						1

Fever

The fever of trichinosis is often described as being plateau in character, with a bradycardia resembling typhoid fever.[3] This was not true of this epidemic. When questioned specifically, 15 patients gave a history of high temperature rise—from 101 to 104 F. during the late evening or night with a return to or near normal during the day. The charts of 2 of the hospitalized patients are included herein and show a remittent fever with nightly rises to as high as 104 F. The respiratory rate remained essentially normal. The febrile period lasted characteristically seven to ten days.

Severe drenching sweats observed in the 3 hospitalized patients disappeared as the temperature curve remained normal.

The frequency of a cough as a symptom was interesting and was thought to represent parenchymal or bronchial irritation by the larvae. Frothy white material was raised, but examination failed to show any parasites. The cough occurred during the second or third week and lasted five to eight days. In all patients examined physically, the lungs were negative. Chest plates taken in 2 cases showed no evidence of parenchymal disease except a slight bilateral density above the hilum in 1 case.

Meningeal Symptoms

Meningeal symptoms were quite common, the most frequent being headache.[4] Of the 17 patients who had this complaint, 13 were women. The most severe cases were observed also in women. At times dizziness and sleepiness were associated with the headaches. They occurred during the period of dissemination and in 1 case continued after muscle pain had left. Positive Babinskis were found in 3 cases and remained positive for about ten days. Kernig's and Brudzinski's signs were negative, although the patients did have a stiff neck. During the acute phase, somnolence and lethargy were the rule.

Three patients had noticeable rashes when observed, two of them being diagnosed as measles. In the other case, the rash was an erythematous coloration around the eyes and between the eyebrows. It appeared nowhere else.

Cardiovascular involvement was probable in the 3 patients who were hospitalized and observed for it. In the 2 of whom chest plates were taken, enlargement of the heart to the right was noticed. Both patients were men in the early 30's with no history or physical signs of previous cardiac disease. Hypotension has been mentioned several times in the literature, and 2 of our cases were followed by daily blood pressure recordings.[5, 6] Because both cases were seen after about one and one-half weeks of illness, their normal blood pressures are not known. One patient, a man of 35 years of age, upon admittance had a blood pressure of 115:70. Three weeks later it had dropped to 95:45, although the patient was up and around at this time.

The other patient, a woman of 74 years of age, had a blood pressure upon admittance of 122:82. Her lowest recorded pressure occurred also three weeks later, when it dropped to 100:45. Both were low upon discharge.

Eye Signs

Eye signs were observed in all but 3 patients, 2 of these having histories obtained by mail. Injection and swelling were most common, while conjunctival hemorrhages were positively identified in only 2, but many have been present in others and disappeared at the time of the examination. Photophobia was a frequent complaint and necessitated the use of colored glasses in some cases. In 2 patients, profuse lacrimation was also present. Eye edema has already been mentioned. It was palpebral, bilateral, did not cause exophthalmos, and was nonpitting in character. In some instances, the eyes were swollen completely shut. Edema elsewhere in noticeable degree was seen in 2 patients. This was located around the jowls and cheeks, lasted about five days, and appeared with larval dissemination.

Muscle tenderness, soreness, and weakness were observed in all the patients. It was worse upon movement in all but 2 patients. The back, thighs, and calves were most frequently involved; the shoulders and neck in some; and in 4 patients, the upper arm muscles. The forearm was apparently unmolested. The masseters were painful in 2 patients, with 1 patient experiencing difficulty in swallowing. The muscle affliction appeared after the gastrointestinal phase of the disease and was associated with entrance of the larvae into the muscles. It was concurrent with the febrile period and occupied generally the second through the fourth weeks. After the soreness left, the patients experienced extreme weakness.

Relationship Between Eosinophilia and Trichinosis

The relationship between the eosinophilia and the disease has long been a matter of controversy. Blood smears were made on as

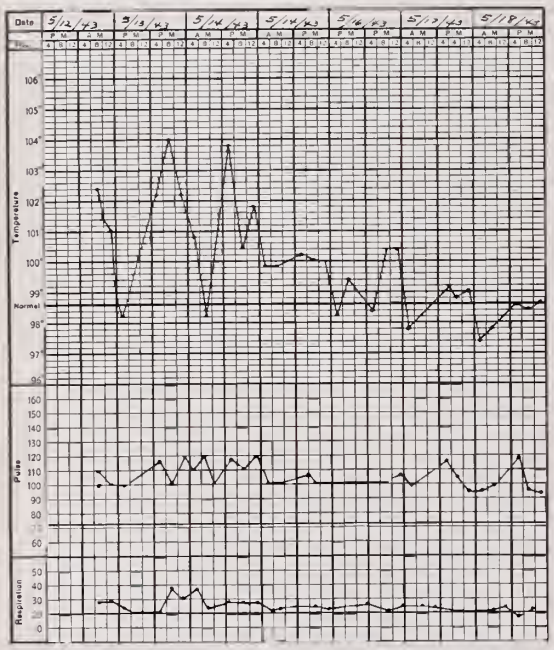


Fig. 1.—This patient had been ill about one week prior to admittance. His temperature remained normal after May 18. His white count rose from 15,000 on May 13 to 18,000 on May 17 and then fell slowly. Eosinophils were 14 per cent on May 13, rose to 38 per cent on May 19 and dropped to 21 per cent where they remained until he left the hospital. The lymphocytes were 12 per cent on May 13, dropped to 8 per cent on May 19 and then rose to 29 per cent where they also stayed until dismissal.

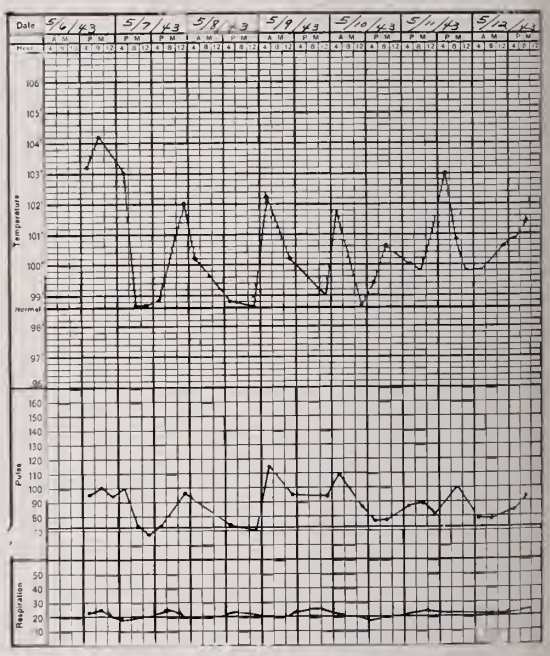


Fig. 2.—This patient ran a fairly long course. He had been ill somewhat less than a week prior to admittance. His temperature did not come to normal until May 16. In this case the blood eosinophilia and total leucocytosis follow fairly well the acute febrile course of the disease. (See Figs. 3 and 4)

many patients as possible; generally this was done during the second or third week of the disease, but total counts were made every forty-eight hours. Because these counts showed the blood picture to be a changing one, we felt that a single differential did not mean much. However, our results are as follows: The lowest eosinophilia was 10 per cent and the highest 62 per cent; the highest leucocytosis was 51,250 and occurred on the patient with the 62 per cent eosinophilia. The rest ranged from 10 to 53 per cent with a mean of about 35 per cent. The eosinophilia of the hospital cases was ascending, the rising curve paralleling the course of the disease and the peak marking the point from which improvement occurred. It is interesting to note that 1 patient had an exacerbation of symptoms in the third week with recurrence of pain in the jaws, lethargy, and eye edema and that with this recurrence, her eosinophils, which had been dropping, rose from 18 to 25 per cent. The relationship among the polymorphonuclear lencocytes, lymphocytes, and eosinophils was interesting. Bacon mentions a lymphocytosis,[7] while Kaufman remarks on the immaturity of the polymorphonuclear leucocytes.[3] In our cases which were followed day by day, a relative lymphopenia was the rule. In 1 patient with 45,000 white cells, only 4 per cent were lymphocytes. The proportion of polynuclear neutrophils was fairly stable, though it became slightly subnormal as the case improved. The percentage of immature cells was relatively low. The most severe of our hospitalized cases had the highest eosinophilia. It was noticed also that the toxicity of the eosinophils (graded from 1 plus to 4 plus depending on the size of granules and fragmentation of the nuclei) increased as the disease progressed.

There was an increase in hemoglobin and red blood cells at the beginning of the disease

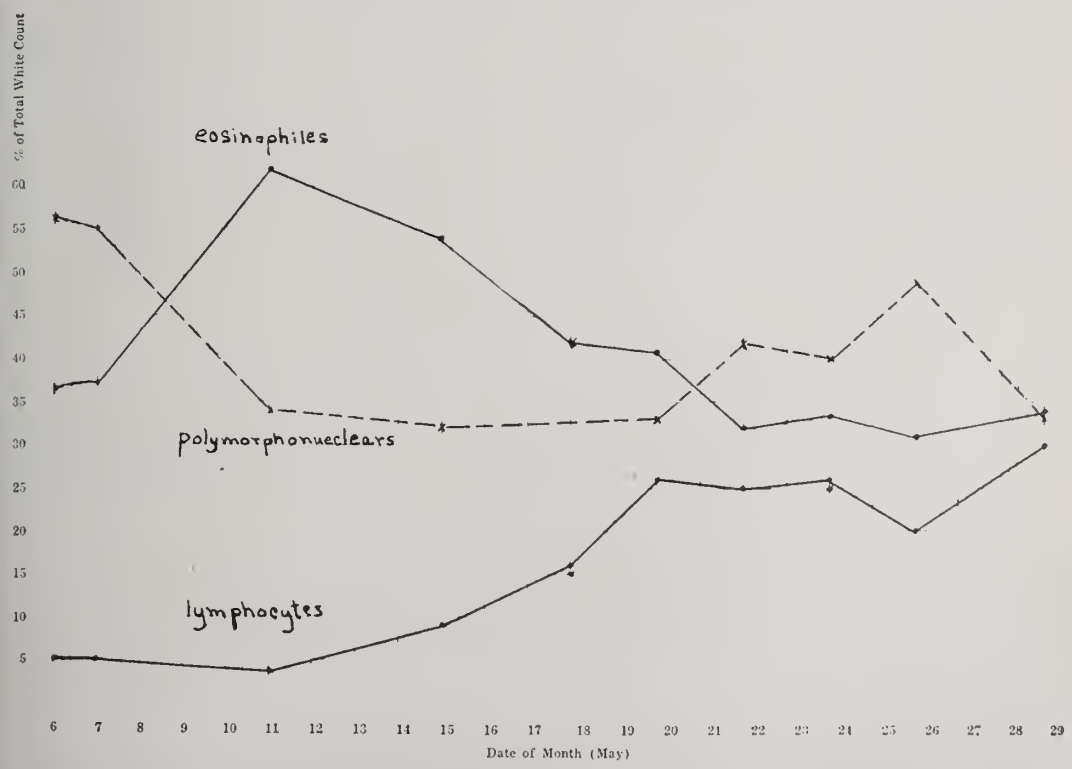


Fig. 3.—The above graph of the blood picture on the patient whose temperature is charted on Fig. 2, shows the relative lymphopenia as well as the eosinophilia. Since the patient had been ill since May 2, the peak of the eosinophilia arrived with larval dissemination and entrance into the muscle. This corresponded to the febrile period although it started a little later and lasted a little longer.

in 1 patient. In all 3 patients the hemoglobin and red cells fell somewhat, though never to more than slightly subnormal levels.

Stool specimens taken of 3 patients during the second week were negative. Spinal fluid from 2 patients which was centrifuged also failed to reveal the parasite.[8] Sputum examination yielded no results. Four muscle biopsies were done, two on the same patient, and three were positive for the larvae. Fresh muscle fibers teased onto glass slides, as well as hemotoxin-stained and eosin-stained sections, revealed the Trichinella. The stained sections showed profuse inflammatory reaction with a great deal of infiltration in the muscle. One biopsy taken during the fourth week showed the larvae alive and able to move. This was seen on fresh muscle fibers teased onto a slide. This patient had received 30 grains of calcium gluconate with twelve drams of cod liver oil for one and one-half weeks previous to the biopsy.

Urine examination in a severe case showed evidence of kidney damage, as albumin, casts, and some red blood cells and pus cells were found early in the disease. These disappeared in later specimens. A few pus cells were found in two other cases, and a trace of sugar in one.[9]

Effectiveness of Treatment

Treatment was felt to be of no avail. Purging with castor oil and calomel was of doubtful benefit; moreover, this was probably started too late to be effective. Cod liver oil and calcium, with some parathyroid hormone in one case, were given in large doses. Despite the low blood calcium, only 4.8 mg.

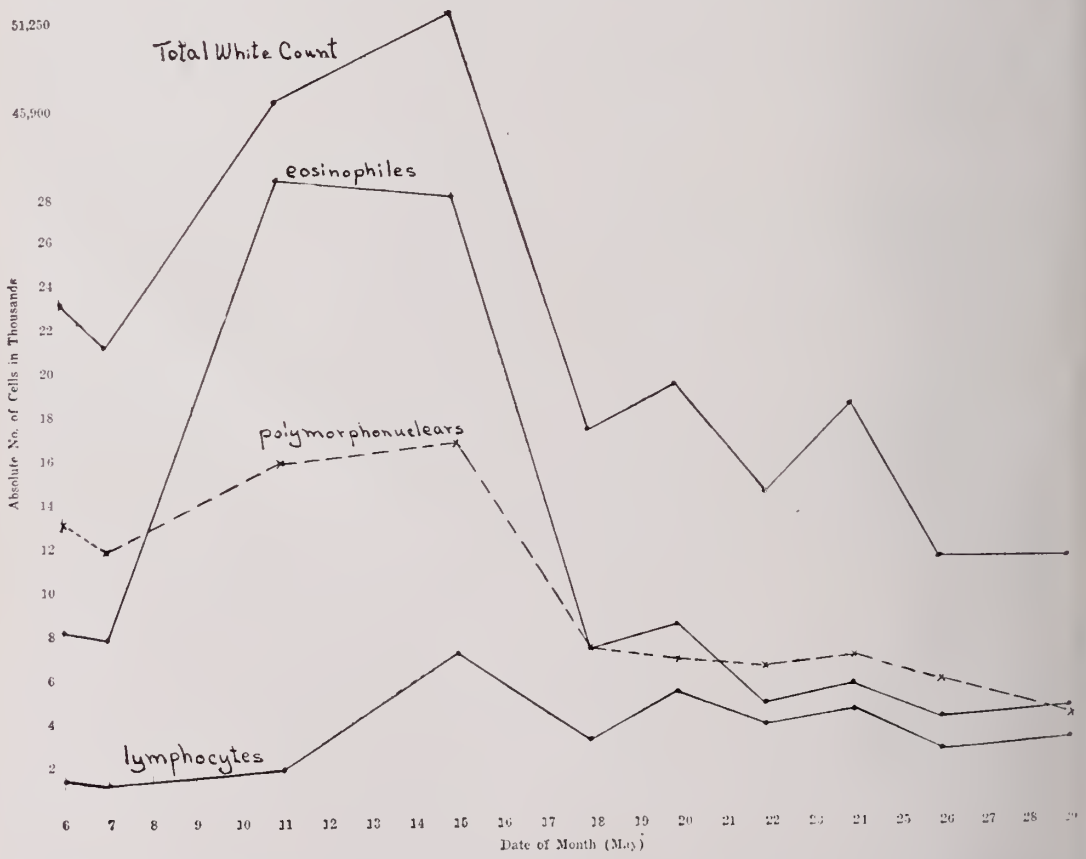


Fig. 4.—This graph of the same patient as Fig. 3 shows the absolute number of polymorphonuclear eosinophils and lymphocytes, as well as the total white count. The absolute number of eosinophils and the total number of white cells is increased during the period of larval dissemination and muscle entrance and the febrile period.

in 1 case and in another 4.4 mg., those without treatment did as well as those with it. (The foregoing blood levels of calcium were taken in patients receiving treatment. Sedatives were used where necessary.) One week later the blood calcium on these patients was 6.2 and 10.4 mg., respectively. Phosphorus was 3.8 and 3.9 mg. at the time the first sample was taken.

Residual symptoms about five weeks after the start of the epidemic are weakness and weight loss. No known case of anemia developed, though the red blood cells fell a few hundred thousand in the cases observed with repeated counts. The weight loss varied, but was 35 pounds in one patient, 25 pounds in another, and 10 or less in many others. The weakness in some cases is still quite severe. The eosinophilia was high in 3 patients observed at this time.

Summary

1. An epidemic of 28 cases of trichinosis from eating sausage is reported with a diagnosis made by history, blood counts, and special tests.

2. Symptomatology varied, with mainly the gastrointestinal tract, eyes, and muscles being involved. Chills and remittent fever with meningeal irritations were common. Cardiovascular signs, weight loss, and cough were observed.

3. The blood picture showed eosinophilia of the ascending type and of various degrees, the curve paralleling the course of the disease. Relative lymphopenia was common.

4. Blood counts and skin tests were taken, examinations of the sputum, spinal fluid, and stools were made, and muscle biopsies were performed. Blood calcium was low in two patients.

5. Treatment was ineffective.

6. The acute phase was about three or four weeks, with residual symptoms of weight loss, weakness, and eosinophilia.

BIBLIOGRAPHY

1. McNaught, J. B.; Beard, R. R., and Myers, J. D.: The Diagnosis of Trichinosis by Skin and Precipitin Tests, Am. J. Clin. Path. 11:195 (March) 1941.
2. Wright, W. H.: A Consideration of the Clinical and Public Health Aspects of Trichinosis, Journal-Lancet 62:389 (Nov.) 1942.
3. Kaufman, R. E.: Trichiniasis: Clinical Considerations, Ann. Int. Med. 13:1431 (Feb.) 1940.
4. Hays, R. R., and Sauvageot, J. P.: Trichinosis Encephalitis, Ohio State M. J. 38:538 (June) 1942.
5. Spink, W. W., and Augustine, D. L.: The Diagnosis of Trichinosis, J. A. M. A. 104:1801 (May 18) 1935.
6. McNaught, J. B.: The Laboratory Diagnosis of Trichinosis, Texas State J. Med. 38:255 (Aug.) 1942.
7. Bacon, L. J.: Trichiniasis in Birmingham, British M. J., No. 4225:909 (Dec. 27) 1941.
8. Van Cott, J. M., and Lintz, W.: Trichinosis, J.A.M.A. 62:680 (Feb. 28) 1914.
9. Epidemic of Trichiniasis in a German Battalion, Modern Medicine, p. 108 (May) 1943.

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AMERICAN FOUNDATION FOR TROPICAL MEDICINE

For the six month period ending June 30, 1943, twelve grants amounting to $43,680 were made by the American Foundation for Tropical Medicine, Inc., to eleven North American medical schools, a scientific journal and the Army Medical Museum, it was reported by Dr. Jean A. Curran, executive director, at a meeting of the Executive Committee of the Board of Trustees in New York City on July 23.

These grants, made possible by contributions and pledges for the current year of $66,600 by twenty-one American corporations, are being used to strengthen teaching and research programs in tropical medicine and parasitology at the various schools. The approved projects were selected by the medical committee among a number of applications.

Medical schools to receive grants during the period from April 1 to June 30 were: Cornell University Medical College, Duke University School of Medicine, University of Pennsylvania School of Medicine and Stanford University Medical School. The Journal of Parasitology was also aided.

The New Prophylactic Measures in Tetanus

By CARL N. NEUPERT, M. D.
Madison

CARL N. NEUPERT

Dr. Neupert was appointed State Health Officer of Wisconsin in January, 1943. He received his degree in medicine at the Washington University School of Medicine, St. Louis, in 1925, and his M. S. degree in Public Health at the University of Michigan in 1941.

WHEN the doctor is called to treat an industrial worker or a child who has suffered a deep cut or a puncture wound, he is confronted with the possibility of tetanus infection unless effective methods are used to prevent it. Many individual physicians, hospitals, and clinics routinely give tetanus antitoxin if there is a reasonable chance that soil, road dust or other material likely to contain tetanus spores may have been introduced into the wound. The incubation period of tetanus is usually between one and ten days and occasionally as long as a month or even more. Tetanus antitoxin acts quickly in time to prevent the disease.

In the administration of tetanus antitoxin, the problem of the allergic patient, especially one sensitive to horse serum, immediately presents itself. Often the patient does not know whether or not he has previously had horse serum. In the face of a probable serum sickness lasting several days and occurring a few days after the administration of the serum, there is a temptation to withhold giving it on the likely chance that there are no tetanus spores in the wound. However, if none is given, there is the uncertainty that becomes a worry that the case in question may be one of the exceptional ones in which tetanus may develop. Therefore, passive immunization produced by the administration of antitoxin in horse serum given as a routine measure each time there is a possible exposure to tetanus presents certain objections.

Deaths From Tetanus

Statistics indicate that more than 50 per cent of the cases of tetanus prove fatal and that about half of the deaths from that disease have been in those under 20 years of age during the past ten years in Wisconsin, in spite of a shift away from neonatal and early infancy age groups. Deaths from tetanus in the decade from 1910 to 1920 included thirty-five in the age group under 2 months of age and twelve in the group from 2 to 12 months, or a total of forty-seven deaths from tetanus in children under 1 year of age. On the other hand, the ten year period from 1930 to 1940 showed no deaths in the group under 2 months and only six in all under 1 year, as compared to forty-seven in the earlier decade. The problem of providing protection or preventing deaths is most acute in the age group from 1 to 20, although there are also significant numbers of deaths up to 70 years, depending on the point of view.

However, for the last six years prior to 1940 when the new census bureau classification of causes of death made comparisons impossible, the average number of deaths from tetanus per year including all ages was but seventeen in this state. This raises the question of whether or not tetanus constitutes a public health problem. The industrial surgeon treating wounds of industrial workers cannot disregard the risk of the development of tetanus, especially when there is available a preventive of proven value even though statistics show the death rate to be extremely low. Neither can the physician treating children take a chance. Therefore, regardless of low incidence (kept down by the use of antitoxin, of course) tetanus prevention is a necessity.

Procedures For Prevention

The use of a preventive similar to diphtheria toxoid is readily accepted by parents, especially mothers, as a means of insuring against the development of a disease as much dreaded as lockjaw. They are usually not reluctant to bring their children in for two immunizing doses two or three months apart, especially if a combined toxoid such as alum-precipitated diphtheria and tetanus toxoid can be given in one injection. Whether given alone or in combination, a toxoid produces an active immunity as the result of action of the patient's own blood and tissues, in contrast to a passive immunity resulting from the use of antitoxin. In the latter, the antitoxin is produced by the horse. The antibodies produced by the patient as a result of toxoid administration are not at a maximum in the patient's blood stream until at least a month after the first injection and usually not until at least two or three months, and then usually only after a second injection. It is necessary, therefore, to realize that protection is slow in developing when toxoid immunization is employed as compared with that in the case of antitoxin, and, therefore, protection cannot be presumed to exist until about two or three months after the initial injection. A second dose of toxoid at that time usually results in a rapid rise in the level of immunity in five to seven days, and when alum-precipitated toxoid is used, the high level of immunity usually lasts six months to a year. This is in contrast to the protection afforded by antitoxin, which usually lasts but two to three weeks. An important advantage in the use of the toxoid is that if an additional dose (called a boosting dose) is given at the end of a year or even after four years, there is a prompt response on the part of the individual which produces a high level of immunity. All of this occurs without sensitizing the individual to horse serum.

To be reasonably sure of adequate protection, it is advised that a second dose be given not less than three months after the initial dose and that a boosting dose be given a year later or at the time of injury any time after six months.

The United States Army now requires three doses of plain toxoid in intervals of not less than three or more than four weeks plus a stimulating dose in one year or upon entering the theatre of war or at any time when injured.

The United States Navy now requires two doses of alum-precipitated toxoid eight weeks apart and a stimulating dose in four years and on injury.

The French Army has used plain tetanus toxoid (three doses) for a number of years without a single case of tetanus developing in those immunized. Tetanus, typhoid and paratyphoid, and diphtheria toxoids are combined in the usual three injections by the French with apparently complete protection against all three diseases.

The English Army is said to use typhoid-paratyphoid vaccine and plain tetanus toxoid in three doses at weekly intervals with a stimulating dose of tetanus toxoid in one year.

For practical purposes any of the above procedures is effective in preventing tetanus. In reviewing the literature, one is struck by the variation as to the amount of antitoxin per cc. of patient's blood held by different investigators to be the minimum protective concentration. Whether 0.1 or .01 units per cc. is accepted seems relatively unimportant to the practitioner who does not have facilities to determine blood titer but must be sure that there is enough for protection. When more complete agreement is reached, a more definite or more uniform procedure can be set up; but, in the meantime, the practices of the Navy or of the Army can probably be adapted to meet needs.

Extent of Use of Preventives

Assuming that tetanus toxoid used as suggested above affords protection against tetanus, the question comes up as to how widely it is being used and in what manner. Replies to inquiries of state health officers in the East, the West, and here in the Middle West were unanimous in that no mass immunization programs were under way or contemplated. As one stated: "In case of injury requiring treatment to prevent tetanus, how

is the physician then attending the case to know whether to give a prophylactic dose of antitoxin or a booster dose of toxoid?" In practically all states, individual physicians, especially pediatricians, were reported as using combined tetanus toxoid. The Connecticut State Medical Society's public health committee recommends alum-precipitated toxoid in three doses two months apart. Some of the state departments volunteered that they distribute tetanus toxoid free to physicians along with other biologic products; others have it available to physicians at cost, and still others leave the matter of obtaining the material to the individual physician.

City health departments contacted are likewise not using tetanus in mass immunizations, although some are using tetanus toxoid in combination with diphtheria in immunizing preschool children when parents request it.

In industry, especially in plants working on war contracts, where large numbers of workers are being recruited from among the unskilled with an increased number of accidents as a result, there is an increasing use of the toxoid.

From this data it would appear that tetanus toxoid is not being used on a mass immunization basis such as is the case with diphtheria and smallpox but that it is being used quite generally on an individual basis by physicians as a preventive. This seems to be especially true of the pediatricians.

In its general use, it is well for the user to remind himself that immunity from tetanus toxoid develops rather slowly so that only after a second dose given about three months after the first can it be assumed with reasonable certainty that the patient is protected; that this immunity is not permanently high but requires a boosting dose in about a year or more or at the time of a subsequent injury, which produces a prompt restoration of the high titer of the blood; and, finally, that alum-precipitated toxoid is probably the preparation of choice, although there is not complete unanimity of opinion regarding the latter.

The Treatment of Civilian War Injuries*

By WARREN H. COLE, M. D.
Chicago

WARREN H. COLE

Dr. Cole received his degree in medicine at the Washington University School of Medicine. A fellow of the American College of Surgeons, he is head of the Department of Surgery, the University of Illinois College of Medicine.

IN THE consideration of the treatment of civilian war injuries, it must be strongly emphasized that there is a marked difference between the treatment of wounds encountered during civilian life and those inflicted as the result of battle. There are several major differences, each of which alters the therapy. In the first place, much more dirt and many more foreign bodies will be encountered in war wounds. Likewise, there will be a greater destruction of tissue in war wounds, thereby leading to a greater incidence of or tendency to the development of gas gangrene and tetanus. The compound fractures seen in war wounds are likely to be of the direct type, as compared with the indirect type seen in civilian life. In the former group, there will be much more comminution and a greater number of foreign bodies. One of the most significant differences between civilian and war wounds lies in the fact that the time interval between the infliction of the wound and its therapy is much longer in war. This is of extreme

* Presented before the One Hundred First Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1942.

importance, since, being badly contaminated, war wounds must have expert care, including thorough débridement, if infection is to be avoided, even though practically all war wounds are now left open. Although transportation facilities for the wounded soldier have improved remarkably during the present war, there still remains a long time interval, known as "time lag," between the infliction of the wound and the treatment.

The wounds occurring in civilians as the result of bombing or other military activities have characteristics between those described as civilian wounds and war wounds. However, they resemble more closely the wounds inflicted in battle, since most of them are the result of explosion of bombs, falling debris, and the like. Therefore, there may be an enormous amount of dirt and foreign bodies in the wounds, and compound fractures will be of the direct type. The interval between infliction of the wound and administration of treatment varies considerably, depending upon the number of injured and the transportation.

Contused Wounds

In reality, contusions are of minor importance, chiefly because the infection element is not present as a complication. It should be remembered, however, that serious fractures and serious intrathoracic as well as intra-abdominal and intracranial injuries may be sustained when nothing more than a contusion is visible on inspection and examination. Therefore, the patient must be examined for the possibility of serious internal injuries. If such injuries, including fractures, are not present, the wound then becomes trivial. Treatment of a simple contusion consists of the application of cold and pressure for a few hours in an effort to minimize the amount of bleeding. Several hours after infliction of the wound, heat is preferred to cold, since the increased vascularity resulting therefrom will facilitate the reparative processes. An improvement in the vascularity may be quite important, because considerable destruction of tissue at times is present in contused wounds.

Open Wounds

Open wounds may be described as being abrasions or incised, lacerated, or punctured wounds.

The treatment of abrasions is of little consequence, since infection is unlikely if reasonably good therapy has been extended. Washing the abrased area with soap and water, sprinkling it with one of the sulfonamide compounds, and applying a dressing usually constitute all the therapy indicated.

Although many different types of antiseptics have been utilized in local therapy of abrasions, most of them are so irritating that they do more harm than good. However, a 1/1,000 solution of acriflavine is so free from irritating qualities and is such an effective antiseptic that it can be recommended for local application in abrasions.

The treatment of punctured wounds may consist of conservative or operative care, depending upon the amount of contamination. A punctured wound inflicted by a sharp, clean object, such as a knife blade, need not be subjected to débridement except when injury to important internal organs is probable or possible. On the other hand, practically all punctured wounds in wartime must be subjected to débridement, since the foreign body inflicting the wound, which is usually a piece of a shell casing or flying debris, is apt to carry in so much dirt and produce so much destruction of tissue that débridement is essential to prevent serious infection.

Treatment

In general, abrasions and punctured wounds (in the absence of buried foreign bodies) are treated by nonoperative measures, whereas incised and lacerated wounds practically always need operative care unless they are seen so late that infection has already developed.

1. Control of Hemorrhage

Usually control of hemorrhage will be limited to first-aid therapy. However, on certain occasions bleeding may still be present by the time the patient reaches the hospital or may have recurred after having been con-

trolled previously. In general, too much emphasis is placed on the use of tourniquets in the control of hemorrhage. Remarkably few wounds demand the use of a tourniquet, since simple pressure with a dressing in the wound will control the bleeding under most circumstances.

If a tourniquet is to be used, it should be applied over a towel or several layers of gauze to prevent local injury of tissue. It must be applied tightly enough to cut off the arterial supply, since application with sufficient pressure to cut off the venous and not the arterial supply will *increase* the hemorrhage instead of obliterate it. On the other hand, the pressure should be little more than sufficient to block the arterial blood, since severe damage to tissues, including particularly the nerves, may be sustained. The tourniquet must be released every thirty to forty minutes lest the resultant total ischemia give rise to gangrene. The duration of the release is dependent upon the amount of bleeding resulting therefrom but in most cases need not be longer than ten to twenty seconds. Tourniquets should not be applied underneath clothing lest they be forgotten or not observed. A neglected tourniquet would result in gangrene of the extremity distal to it.

The amount of shock present will be dependent primarily upon the amount of blood lost, although trauma may also lead to shock. Since the shock resulting from hemorrhage is due to loss of blood, it is obvious that restoration of the blood volume is necessary. Since the constituents lost consist of blood itself, the best agent to use is a blood transfusion. Plasma should be used if a cross-matched donor is not immediately available. Plasma is very effective in combating shock due to hemorrhage, but it should be emphasized that blood is superior in this instance.

2. Treatment of Shock

As intimated in the foregoing material, shock may be caused by hemorrhage or by trauma itself, including particularly the crushing of tissues by solid objects or by blast. Both factors will play a role in a great many cases. The hemorrhage must be controlled immediately. The patient must be handled gently, particularly in respect to the sites of injury, and must not be submitted to additional trauma. Complete immobilization, including the use of the recumbent position, should be maintained as long as the injury appears to be serious. Fractures should be splinted before the patient is transported. Body heat must be conserved, but the recent work of Blalock and others[1] suggests that application of considerable heat may be very harmful in shock. Pain must be controlled by adequate doses of sedatives, but judgment must be exercised, because a narcotic may mask manifestations pointing toward some serious undiagnosed condition.

Blood or plasma is indicated immediately. Plasma has an advantage over blood in that it need not be matched if it is properly collected in a pooled fashion. Moreover, blood cannot be stored longer than eight or nine days without giving rise to serious reactions. Plasma may be stored for months or years. It appears to keep indefinitely when stored in the dried state. If frozen and kept below freezing temperature, it will likewise keep almost indefinitely. When kept in a liquid state, it will keep for several months but should be stored in a refrigerator at 2 C. to 4. C. At the present time, practically all the dried plasma being manufactured is being sent to the armed forces.

Numerous blood substitutes are available for use in case blood or plasma is not immediately available. A 5 per cent glucose or 0.9 per cent saline solution is most commonly used. It should be emphasized, however, that these solutions may actually deplete the body of electrolytes and proteins unless blood or plasma is also given. Human albumin is extremely effective in combating shock[2] and has an effectiveness equivalent to several times its volume of blood or plasma. Considerable work is being done on the possible use of bovine plasma,[3] but at the present time reactions appear to be too prevalent to allow generalized use. Bovine albumin[4] appears to offer promise from the standpoint of decreased reaction, but more work needs to be done before routine use is to be adopted.

Drug therapy is limited to a few agents in the therapy of shock. Oxygen is important and should be administered to all patients suffering severe shock. Cortical extract (adrenal) may be used, but its use is still in the experimental stage. If adrenal extracts are used, the actual extract of the cortex should be used and not the synthetic desoxycorticosterone; the latter substance is extremely potent in treating adrenal insufficiency such as Addison's disease, but preliminary experiments with it in shock reveal its effectiveness to be doubtful. Epinephrine and pituitrin, which were originally used, are *strongly contraindicated,* since there is a sharp depression in the blood pressure as soon as the immediate effect of the drug wears off.

3. Examination for Extent of Injury

A thorough examination must be conducted to determine whether or not certain nerves or tendons are injured. It is very important to know whether or not a joint capsule has been injured by the wounding agent, but this factor can be determined at operation. Naturally, fractures should not be overlooked.

4. Operative Treatment

As previously stated, the interval between infliction of the wound and its treatment determines the type of therapy. If the wound is more than ten or twelve hours old, it will obviously be infected unless sulfonamide has been used locally, and débridement may therefore be contraindicated because of the possibility of activating an infection already present. However, as just stated, all wounds which have been treated by local implantation of sulfonamides can, with very few exceptions, be subjected to débridement without danger of activation of infection. The experiences at Pearl Harbor decisively proved that the local implantation of sulfonamides in a wound would permit débridement even though twelve to thirty-six hours might have elapsed since infliction. If a wound is relatively trivial, associated with a small amount of trauma, and not badly contaminated, it can usually be closed after thorough débridement as early as four to six hours after infliction. This element of time lag is one of the most important factors in the question as to permissibility of closure following débridement, as has been known for many years and recently re-emphasized by Jolly,[5] Fruchaud,[6] and others.

Certain features in débridement are particularly important. The most important feature lies in the fact that the débridement must be thorough and skillfully done, with removal of all foreign bodies and devitalized tissue if subsequent infection is to be minimized or eliminated. The surgeon should be masked and wear sterile gloves. The skin around the wound should be cleansed with soap and water, and the wound itself should be thoroughly irrigated with physiologic saline. The wound is then draped with sterile towels and all devitalized tissue and foreign bodies removed. The skin edges should be trimmed with a sharp knife. After the superficial portion of the wound is cleansed, it is preferable to use a new set of instruments and sterile gloves. Gentleness during this process of débridement must be maintained. No hemostats should be applied except to bleeding points. When vessels are ligated, small hemostats must be used and fine ligatures likewise utilized. If the wound is to be closed, cotton or silk is the ligature of choice.

Closure of the wound is a very important procedure and requires the utmost judgment. In general, all wounds inflicted by the usual mechanisms of war, such as bombing or shrapnel, must be left open after débridement. Most of the wounds at Pearl Harbor were treated by thorough débridement and the application of tension sutures without closure of the wound.[7] If, after three to four days, infection is absent or minimal, these stay sutures may be tied, thereby approximating the wound edges.

It seems obvious now that drains should rarely be used in closed wounds, since they rarely lessen the incidence of infection and probably actually increase it. This is particularly true of gauze wicks.

As intimated, sulfonamide therapy represents one of the greatest advances in the care of wounds, particularly as related to the incidence of infection and the ultimate results. It is good therapy to sprinkle several grams of sulfanilamide (using not more

than 10 Gm. per patient) into the wound as soon as the patient is found, unless definitive treatment can be carried out immediately. If a decision has been reached not to close the wound but to pack it open, several grams of sulfanilamide are sprinkled into the wound and a vaseline pack applied over it. Thereafter, unless oral intake is contraindicated, sulfanilamide therapy is continued by mouth in doses equal to about 1 Gm. every four hours. When oral therapy is not feasible, sulfanilamide may be given subcutaneously or intravenously in a 1 per cent solution of saline in doses equivalent to 5 or 6 Gm. per twenty-four hours. Sulfanilamide therapy should be maintained for four or five days after the operative treatment unless the wound is trivial. Sulfadiazine is perhaps more effective in preventing the growth of the gas bacillus, as is indicated by the experimental work of Dowdy and associates.[8] Recent work in our clinic and elsewhere suggests that sulfadiazine may be superior to sulfanilamide as the drug for local implantation, in so far as it has a greater specificity for organisms and is less toxic than sulfanilamide. It is much less soluble than sulfanilamide and, therefore, should not be applied in huge quantities in small wounds. I am of the opinion that such huge quantities are not necessary and do not increase the efficiency of the sulfonamide therapy, particularly since large doses appear to lead to local tissue reaction with consequent interference in wound healing. If the wound is very extensive, several grams of any sulfonamide including sulfadiazine can be applied without risk of lumps forming. In our clinic, with the use of sulfadiazine in abdominal wounds we have not observed a single instance of "caking" of the drug. If sulfadiazine is chosen as the preferred drug and oral intake is not possible, the drug may be administered intravenously in the form of sodium salts. It can be made up in a 5 per cent solution in distilled water, but it should be emphasized that the solution *should not be heated or sterilized.* Moreover, sodium sulfadiazine is quite alkaline and *should not be given subcutaneously or intramuscularly.* It is well tolerated, however, when given intravenously.

5. Anesthesia

Numerous anesthetic agents are available for use in operative repair of wounds. Choice depends largely upon the skill of the available anesthetist. If the anesthetist is relatively unskilled, drop ether will be the anesthetic of choice. Local anesthesia will be very useful in a large percentage of cases. Intravenous and spinal anesthetics are extremely poorly tolerated by patients who have received wounds in bombing raids. Perhaps this may be explained by the serious effect of the blast which produces serious shocking symptoms.

6. Immobilization

One of the most effective measures in the treatment of infection and one which is perhaps least appreciated is complete rest of the injured part. It is well known that trauma of tissues, even though of no greater intensity than that inflicted by slight movement, tends to encourage the development of infection. If the wound is very extensive, the patient must even be put to bed. It is possible that part of the splendid results achieved in the plaster cast therapy of extensive wounds is due to the complete immobilization created by the cast. The advantage of the use of a plaster cast in the treatment of extensive wounds even without fractures was perhaps first definitely demonstrated in the recent Spanish Revolution, as has been reported by Trueta,[9] Jolly,[5] and others.

7. Injury to Special Structures

Thorough examination must be made to be certain that all injuries are detected and treated. It has recently been demonstrated that lacerated tendons cannot be repaired without a high incidence of infection unless they are received within three or four hours after infliction of the injury. If more than four or five hours have elapsed since injury and contamination is more than trivial, it is usually preferable to perform a débridement of the wound with closure but without any attempt to suture the tendons. Several weeks or a few months after the wound has completely healed, an operation is performed to suture the tendon. Repair under these

reasonably sterile conditions will lead to primary healing and obliterate the serious consequences incident to infection. For obvious reasons, intra-abdominal, intrathoracic, and intracranial lesions take precedence in the operating room when a large list of casualties is on hand. Obviously, any large sucking wounds of the thorax must be closed instantly or very soon after infliction of the wound if a fatality is to be prevented. This treatment is, of course, a first-aid measure, and, if the dressing is applied properly, it will be sufficiently airtight to prevent a fatality resulting from the open pneumothorax. Experience with abdominal wounds at Pearl Harbor revealed the advisability of excising the wound of entry, packing it with sulfanilamide, and entering the abdomen through a separate incision.

8. Therapy against Anaerobic Infections

Part of the therapy already discussed is directed primarily toward the prevention of anaerobic infection, of which tetanus and gas gangrene are the most outstanding. The chief factors in the therapy already discussed having to do with prevention of anaerobic infections are the excision of devitalized tissue and the removal of foreign bodies. It is likewise known that closure of wounds encourages development of anaerobic infections, whereas packing the wound open discourages them.

In civilian life, an important prophylactic measure against tetanus is the administration of 1,500 units of antitetanic serum. In serious wounds, this dose should be increased to 3,000 units. It must be remembered that the immunity conferred by the prophylactic dose of tetanus antitoxin lasts only about two weeks. If any operative or manipulative procedures are contemplated after this interval, another dose of antitoxin must be given.

At the present time, all military personnel is being immunized against tetanus with toxoid. This effective active immunity lasts for years and has numerous advantages in so far as the possibility of sensitization and reaction to horse serum is eliminated. The toxoid is given in three doses at intervals of three or four weeks. When a wound is inflicted, a booster dose of toxoid is given to increase the immunity. It is very significant that in all of the injuries at Pearl Harbor, not a single case of tetanus was encountered. It is probably true that practically all the Navy and Army men injured had had active immunity conferred by toxoid. It is difficult to determine whether the toxiod or the use of sulfanilamide and packing of the wounds open was responsible for these miraculous results in eliminating tetanus.

Since very few civilians will be immunized with toxoid, the prophylactic injection of antitetanic serum will have to be utilized in the treatment of civilian wounds even though these are inflicted by military invasions.

If active tetanus develops, the prognosis is, of course, grave. Although the mortality rate a decade ago was as high as 50 to 70 per cent, it has now been reduced to 25 to 30 per cent. Since relatively the same amount and type of antitoxin was used then as compared to now, it would appear that the difference in mortality rate was not related to antitoxin. This furthermore implies that antitoxin may not be of very great value in the treatment of an actual case of tetanus. Moreover, this drop in mortality rate was obtained before sulfonamide therapy was available. Therefore, it becomes quite obvious that another of the recent new additions to the therapy, namely, sedatives, is responsible for the improvement in results. These points have been recently discussed by Spaeth,[10, 11] who likewise is convinced that sedation is the most important factor in treatment. He recommends the use rectally of avertin in amylene hydrate and of sodium amytal by the oral or intravenous route. I agree with Spaeth in his conclusion that the intraspinal method of administration of toxin probably does more harm than good as far as end results are concerned. Spaeth recommends administration of 30,000 to 60,000 units intravenously as the initial dose. Smaller doses are required thereafter, since the antitoxin is secreted or destroyed relatively slowly following such a large dose.

The same prophylactic procedures directed against tetanus are effective against gas gangrene, except that antitoxin is probably not as effective in prophylaxis. However, a

dose of polyvalent gas bacillus antitoxin, which ordinarily contains antitoxin against Welch's bacillus, Bacillus edematiens, and vibrion septique, should be given prophylactically. The relationship of closure of wounds to development of anaerobic infections, particularly gas gangrene, is emphatically emphasized by the fact that of the 11 cases of gas gangrene encountered at Pearl Harbor,[12] all were in cases in which the wound had been closed by primary suture.

After gas gangrene has developed, treatment must be immediate and dramatic to prevent fatality. Operation, including adequate drainage and excision of devitalized tissue, particularly muscle, remains a very important factor in therapy. Sulfonamides appear to be important in the treatment of gas gangrene. Originally, sulfanilamide was recommended and used. In view of the experiments of Dowdy and associates,[8] it appears that sulfadiazine may be more effective than either sulfathiazole or sulfanilamide. Antitoxin should likewise be given. I am of the opinion that antitoxin for active gas gangrene is more effective than tetanus antitoxin in the treatment of active tetanus. Results, however, would perhaps be inconsistent depending largely upon whether the strain of the organism happens to correspond with the strains used in the manufacture of toxin. Roentgenism has been advised by Kelly[13] in the active treatment.

BIBLIOGRAPHY

1. Blalock, A.: A Comparison of the Effects of the Local Application of Heat and of Cold in the Prevention and Treatment of Experimental Traumatic Shock, Surgery 11:356 (March) 1942.
2. Cohn, E. J.: The Properties and Functions of Plasma Proteins, With a Consideration of Methods for Their Separation and Purification, Chem. Rev. 28:395 (April) 1941.
3. Kremen, A. J., and others: Studies on the Intravenous Administration of Whole Bovine Plasma and Serum to Man, Surgery 11:333 (March) 1942.
4. Davis, H. A., and Eaton, A. G.: Intravenous Administration of Bovine Serum Albumin as a Blood Substitute in Experimental Secondary Shock, Proc. Soc. Exper. Biol. & Med. 49:20 (Jan.) 1942.
5. Jolly, D. W.: Field Surgery in Total War, London, Hamish Hamilton Medical Books, 1940.
6. Fruchaud, H.: Treatment of Recent War Wounds, French and Spanish Methods, Lancet 242:725 (June 20) 1942.
7. Strode, J. E.: Observations on the Treatment of War Wounds, Hawaii M. J. 7:158 (Jan.) 1942.
8. Sewell, R. L.; Dowdy, A. H., and Vincent, J. G.: Chemotherapy and Roentgen Radiation in Clostridium Welchii Infections, Surg. Gynec. & Obst. 74:361 (Feb.) 1942.
9. Trueta, J.: Treatment of War Wounds and Fractures, London, Hamish Hamilton Medical Books, 1939.
10. Spaeth, R.: Therapy of Tetanus, Arch. Int. Med. 68:1133 (Dec.) 1941.
11. Spaeth, R.: Tetanus, Am. J. Nursing 42:733 (July) 1942.
12. Halford, F. J.: Gas Gangrene and Tetanus, Hawaii M. J. 1:169 (Jan.) 1942.
13. Kelly, J. F.: The X-ray as an Aid in the Treatment of Gas Gangrene, Radiology 20:296 (April) 1933.

A. M. A. JOURNAL SAYS HOSPITALS SHOULD NOT PRACTICE RADIOLOGY

In an editorial discussing the place of radiology (radium and x-ray) in new forms of hospitalization insurance as well as its place in routine hospital service, *The Journal of the American Medical Association* for July 31 declares that "Education of the public as to the significance of radiologic practice is important in this direction.

"Doubtless few of those who obtain the services of radiology in hospitals realize that in many institutions the radiologist is working for a small salary and the hospital is deriving a considerable profit from his professional practice. In other institutions what amounts to virtual fee splitting between the hospital and the radiologist is routine technic.

"Certainly it is not to the interest of the patient, who must be given first consideration, that the necessity for radiologic study of his case should be made the occasion for providing excess income for the hospital. If the trend is to be controlled, every new arrangement between a hospital and radiologist and every new plan for a prepaid medical service should be carefully scanned by the county medical society in the area concerned to determine whether or not it violates the fundamental tenents that have been so often iterated and reiterated by the House of Delegates of the American Medical Association.

"The danger to the sick does not lie in the collection of income for the hospital or the radiologist; it is in the inevitable deterioration that must come in any form of medical service when its practitioners are placed on a basis in which the quality of the service rendered is secondary to the price charged or the method by which the service is supplied."

Colloid Carcinoma of the Gastrointestinal Tract

Occurence in a Boy Twelve Years Old With the Production of Pseudomyxoma of the Peritoneum

By JOSEPH M. KING, M. D., and JOHN J. SATORY, M. D.
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COLLOID or gelatinous carcinoma is as its name indicates, a carcinoma which is soft and slimy because of its mucinous content. It occurs in the breast, stomach, large intestine, and gall bladder, but rarely elsewhere. It has been classified as one of the four types of glandular carcinoma; the other three are (1) scirrhous carcinoma, which occurs chiefly in the breast and stomach; (2) medullary carcinoma, which usually occurs in the breast; and (3) adenocarcinoma, or carcinoma with a definite gland-like structure, found usually in the gastrointestinal tract and breast.

Boyd believes that colloid carcinoma is a colloid degeneration of an adenocarcinoma and that it is not infrequent in the stomach and large intestine. He further states that large masses of gelatinous new growths like sago pudding are formed with great thickening of the bowel wall. Curiously enough, the metastasis has the same colloid appearance as the parent growth.

Ewing states that specific degenerative changes are sometimes highly characteristic of certain glandular carcinomas. Chief among these is the excessive mucous production of gelatinous carcinomas of the gastrointestinal tract, peritoneum, ovary, breast, and other organs which tends to cause rapid increase in the bulk of the tumor while actually retarding the proliferation of tumor cells. Nevertheless, such tumors may prove highly malignant, since the distention of tissue spaces by mucus facilitates the dissemination of the surviving cells. The entire abdominal cavity may be distended with the mucinous material in colloid carcinoma of the intestine, or the entire stomach wall may be thickened and honeycombed by such a growth. Ewing further states that pseudomyxoma of the peritoneum is a form of diffuse implantation tumor arising from mucinous intestinal cancer in which an orginally carcinomatous process becomes greatly altered by a peculiar inflammatory process about masses of mucus.

Pseudomyxoma of the Peritoneum

Pseudomyxoma of the peritoneum is often described as a complication to a mucocele of the appendix, or more frequently this condition may occur as the result of a rupture of a pseudomucinous cystadenoma of the ovary. These are conditions which, when localized, are thought by some to be relatively benign but which, when diffused throughout the peritoneum, give a more serious prognosis.

The case reported below is that of a case of pseudomyxoma of the peritoneum secondary to a colloid carcinoma of the sigmoid colon in a boy 12 years old. From the brief time elapsing between the occurrence of the first symptom and a status of inoperability, it seems that when an adenocarcinoma undergoes mucoid or colloid degeneration it goes on a rampage and invades everything in its path (fig. 1).

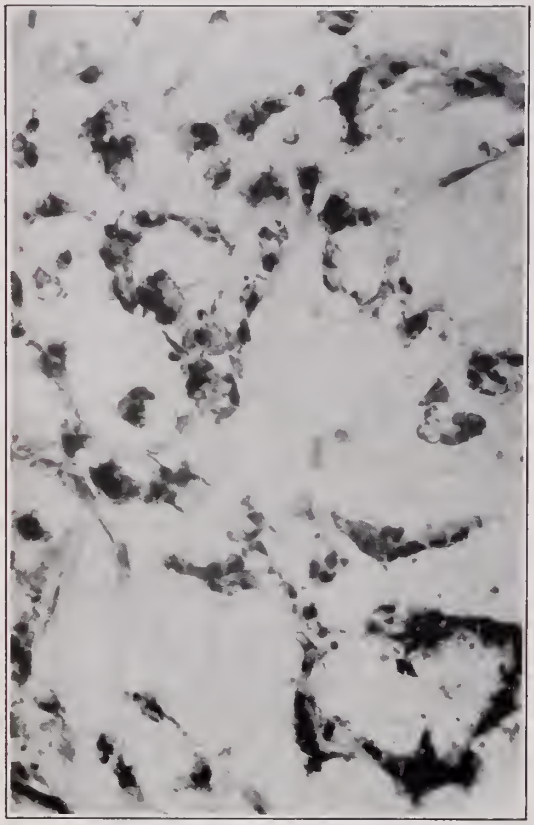

Fig. 1. Photomicrograph of tumor tissue. (High power) Note nests of tumor cells surrounded by mucin.

Fig. 2. Roentgenogram following barium enema. Note filling defect of the sigmoid and descending colon.

Case Report

A white boy, 12 years of age, was admitted to the Milwaukee County Hospital with the complaint of generalized abdominal pain which came on shortly after eating during the three weeks prior to admission. For one week previous to admission, the patient noticed swelling of the abdomen and was constipated during that time. Bowel movements were soft but were diminished in amount. His appetite had been poor.

His past history revealed nothing significant. The child had had chicken pox and mumps several years previously, each without complication.

His parents, one sister, and two brothers were living and well. (The history was verified by the mother.)

Preoperative Diagnosis

Physical examination revealed a pale, thin, and well developed boy who did not appear acutely ill. His temperature was 100 F. (rectal), pulse 88, respirations 20. The tongue was coated. The thorax showed some flaring of the ribs at the lower costal borders. The chest was otherwise negative. There was a soft systolic murmur heard over the pulmonic region. Examination of the abdomen revealed no scars. There was marked distention. The percussion note was tympanitic over the mid portion with dullness in the flanks. Some tenderness was elicited over the right hypochondriac and left lumbar regions. Intestinal peristalsis was present, and evidence of slight ascites was noted. The extremities were thin but otherwise were without significant changes. Rectal examination was essentially negative. The impressions of the intern and the junior resident were that this was a case of Hirschsprung's disease with chronic partial bowel obstruction. Tuberculous peritonitis was also considered.

A roentgenogram of the abdomen taken on admission was negative.

The patient's course in the hospital during the time diagnostic procedures were being performed was without much change. The hemoglobin was 84 percent; the red blood count was 5,180,000; the white blood count was 8,500, of which 61 percent were polymorphonuclear forms, 33 percent lymphocytes, 5 percent endothelial cells and 1 percent were eosinophils. The sedimentation rate was 17 mm. in one hour and 40 mm. in two hours. The Mantoux test was negative.

Abdominal distention increased slightly, even though frequent enemas were given. About a week after admittance, the patient began to complain of considerable pain and would point to the mid epigastrium as the location.

A barium enema showed a filling defect involving the sigmoid and descending colon. No diverticula were shown. The radiologist reported that a carcinoma would have to be considered seriously despite the patient's age (fig. 2).

A laparatomy was performed. When the abdomen was opened, about 2 liters of a brownish serous fluid was found. The large and small bowel were studded with nodules of various sizes, some of which were pigmented. The mesentery, omentum, and peritoneum were thickened and infiltrated with similar nodules of fairly firm tissue which gave a mottled, pigmented, and ivory-like appearance. One small nodule the size of a pea was found in the liver. The greatest amount of localized involvement was at the sigmoid colon, where the tumor seemed to encroach upon the bowel in a ringlike fashion.

Postoperative Diagnosis

The postoperative diagnosis was that of a carcinoma of the sigmoid colon with generalized abdominal metastasis. Because of the extent of the process, no further operative procedure was attempted, and the abdomen was closed.

The pathologic diagnosis was that of a colloid carcinoma of the sigmoid colon with involvement of all of the tissues submitted. (Tissues from the sigmoid, the omentum, and the parietal peritoneum were submitted.)

The immediate postoperative course was uneventful. The wound healed well. The ascites recurred. Enemas were necessary to control distention. The patient went home on the fourteenth postoperative day. He was fairly comfortable and was up and about for short periods. The prognosis was explained to the family before the patient left the hospital, and he died September 9, 1941, at home, approximately three and one-half months after the first symptoms were noticed. No autopsy was permitted by the family.

Summary

1. This is the report of a case of colloid or gelatinous carcinoma of the sigmoid colon with pseudomyxoma of the peritoneum in a boy 12 years old.

2. It is interesting to note the rapidity of growth of a lesion of this type, death occurring three and one-half months after the first symptoms were noticed.

BIBLIOGRAPHY

1. Bell, E. T., Editor: A Textbook of Pathology, ed. 3, Philadelphia, Lea & Febiger, 1938, p. 323.
2. Bell, E. T., Editor: A Textbook of Pathology, ed. 2, Philadelphia, Lea & Febiger, 1934, p. 275.
3. Boyd, William: Surgical Pathology, ed. 3, Philadelphia, W. P. Saunders Co., 1933, p. 295.
4. Boyd, William: Surgical Pathology, ed. 2, Philadelphia, W. P. Saunders Co., 1929, p. 206.
5. Ewing, James: Neoplastic Diseases, ed. 4, Philadelphia, W. P. Saunders Co., 1940, p. 515.
6. MacCallum, W. G.: A Text-book of Pathology, ed. 6, Philadelphia, W. P. Saunders Co., 1938, p. 1116.

DECLARATION OF ESTIMATED INCOME TAX MUST BE FILED BEFORE SEPTEMBER 15

Physicians, and other individuals who derive their income from professional fees, are required to file a Declaration of Estimated Income for 1943, based on the estimated income and deductions for the year, before September 15, 1943. You may take credit against the current tax liability for payments already made on the 1942 assessment. One-half of the remainder will be due September 15, 1943, and the other half December 15, 1943.

Should you underestimate, an amended declaration can be filed on any subsequent installment date during the year. A final and complete return must be filed not later than March 15, 1944. Any necessary adjustments will be made at that time.

Your estimate must not be less than 80 per cent of the actual tax for the year. Should it be less, there shall be added to the actual tax an amount equal to the excess of 80 per cent of the actual tax over the estimated tax, or 6 per cent of the amount by which the actual tax exceeds the estimated tax, whichever is the lesser. In the event of failure to file the declaration within the time prescribed, a penalty of 10 per cent of the tax shall be added.

The Act provides that 75 per cent of the 1942 or 1943 tax, whichever is the lesser is forgiven. Should the 1942 tax be the lesser, the 25 per cent which is not forgiven is payable in two equal installments, one on March 15, 1944, and the other on March 15, 1945. Should the 1943 tax be the lesser, the forgiveness will be made in accordance with the provisions of the Act at the time of filing the 1943 estimated declaration and the final filing of the actual return for 1943.

Thirty-Five Year Survey of Appendicitis in Rock County*

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THOMAS H. FLARITY

THIS survey of appendicitis in Rock County covers a period of thirty-five years in one community and thirteen years in two others where hospitals are located. A total of 6,482 cases were analyzed, with all available data on the histories being used. The older records were incomplete, so that in some instances we have used the period from 1929 to 1942 with 4,327 cases.

Rock County has a population of 80,173, two industrial cities of 25,000 or over, and several smaller towns and villages. There are two hospitals of one hundred beds or more and one of less than fifty beds. While the majority of the patients come from the local communities and surrounding rural areas, many are from adjacent counties. In this survey the different communities in which hospitals are located are referred to as Groups I, II, and III. The distribution of cases is shown in Table 1.

TABLE 1

Group	Years	Cases
I	1907–1942	4,176
II	1929–1942	2,062
III	1929–1942	244
Total		6,482

* Presented before the One Hundred First Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1942.

The Incidence of Appendicitis

The sex and age incidence is shown in Table 2.

TABLE 2

Male	Female	Ratio
2,504	3,414	2 to 3

TABLE 2—Continued

Age	Total Cases	Per Cent
9 years and under	373	5.8
10–19 years	1,498	23.1
20–29 years	1,746	27.0
30–39 years	884	13.6
40–49 years	504	7.8
50–59 years	259	4.0
60 years and over	145	2.2

Percentages in the last line are figured on the basis of 6,482 cases.

One might gain the impression that appendicitis is more prevalent during certain periods, such as the holiday season, or following acute upper respiratory or acute intestinal infections. Table 3 gives the seasonal incidence. There appears to be no significant variation from month to month. In fact, December and January show fewer than the average number of cases.

TABLE 3

Month	Cases
January	445
February	439
March	512
April	433
May	479
June	466
July	485
August	521
September	451
October	429
November	370
December	385

Mortality Rate

The real purpose of this survey is to determine whether the mortality rate in our series compares favorably with larger institutions throughout the country where greater control and supervision of treatment of the disease is exercised. Comparative statistics are available. Table 4 shows the mortality rate for the three groups.

TABLE 4

Group	Years	Cases	Deaths	Per Cent
I	1929–1942	2,025	58	2.9
	1907–1929	2,151	36	1.7 } 2.3
II	1929–1942	2,062	70	3.4
III	1929–1942	244	10	4.0
Total		6,482	174	2.7

It is interesting to note the mortality rate for the different periods in Group I. In spite of the great progress which has been made in surgical treatment in the last few years, the mortality rate has actually increased slightly.

Table 5 shows the mortality rate in the different types of appendicitis from 1929 to 1942.

TABLE 5

Group	Type	Cases	Mortality	Per Cent
I	Acute	965	21	2.2
II	Acute	920	9	1.0
III	Acute	123	1	0.8
I	Gangrenous	79	10	12.8
II	Gangrenous	129	16	12.4
III	Gangrenous	7	0	0
I	Ruptured and abscessed	126	13	10.3
II	Ruptured and abscessed	161	29	18.0
III	Ruptured and abscessed	46	7	15.0
I	Subacute and chronic	855	0	0
II	Subacute and chronic	848	12	1.4
III	Subacute and chronic	68	1	1.5
Total		4,327	119	2.76

Considering the groups separately, Group I has a mortality rate from 11 to 12 per cent in ruptured and gangrenous cases; Group II has 12 to 18 per cent; and Group III, 15 per cent. Group I has twenty-five physicians performing a total of 4,176 operations for appendicitis, with a general mortality rate of 2.3 per cent and a mortality of 11 to 12 per cent in the last thirteen years in ruptured and gangrenous cases. Group II has thirty-eight physicians performing a total of 2,062 operations for appendicitis with a general mortality rate of 3.4 per cent and 12 to 18 per cent in ruptured and gangrenous cases. This fact alone may explain the difference in mortality rate. In Group III the conservative type of delayed operation has been practiced largely without significant variation in the mortality rate. Table 6 shows the summary of all the deaths from 1929 to 1942.

TABLE 6—1929–1942

Type	Cases	Deaths	Per Cent
Grand Total	4,331	138	3.2
Acute Cases	2,008	31	1.5
Gangrenous Cases	215	26	12.1
Ruptured and Abscessed	333	49	14.7
Subacute and Chronic	1,771	13	0.7

Table 7 shows the age mortality incidence.

TABLE 7

Age	Total Cases	Deaths	Per Cent
9 years and under	373	17	4.7
10–19 years	1,498	12	0.8
20–29 years	1,746	27	1.5
30–39 years	884	26	3.0
40–49 years	504	34	6.8
50–59 years	259	32	12.3
60 years and over	145	14	9.7

Table 8 shows the cause of death as determined from the records from 1929 to 1942.

TABLE 8

Cause	Deaths	Per Cent	Total Cases
Peritonitis	78	1.8	4,331
Septicemia	6	Insig.	
Pneumonia	6	Insig.	
Cardiac Failure	5	Insig.	
Thrombosis and Pulmonary Embolus	4	Insig.	
Shock and Hemorrhage	2	Insig.	
Tetanus	1	Insig.	
Carcinoma Sigmoid	1	Insig.	
Cause Undetermined	35	0.8	
Total	138	2.3	

Peritonitis leads the list of causes with 1.8 per cent of the 3.2 per cent total mortality rate. In this tabulation, the word septicemia probably indicates pylephlebitis. Only 4 cases of pulmonary embolus are recorded in a series of 4,331 operations. The fact that there are 35 cases in which the cause of death could not be determined from the record complicates the compiling of statistics. Hospitals should enforce the rule that the cause of death be placed on the records and autopsies obtained if possible.

Table 9 lists the cause of death in the cases of so-called chronic appendicitis.

TABLE 9

Cause	Deaths	Per Cent	Total Cases
Peritonitis	7	Insig.	1,773
Pneumonia	1	Insig.	
Hepatitis	1	Insig.	
Pancreatitis	1	Insig.	
Pulmonary Embolus	1	Insig.	
Chronic Nephritis	1	Insig.	
Paralytic Ileus; Cardiac Failure	1	Insig.	
Cause Undetermined	2	Insig.	
Total	15	0.8	

Table 10 shows the average number of hospital days and for Group II the type of anesthesia used and the chest complications.

TABLE 10—1929–1942

Group	Number of Hospital Days
I	9½
II	10
III	14

Group II

Anesthesia	Cases	Chest Complications	Anesthesia Used
Ether	558	Pneumonia	N_2O plus O plus ether
Ethylene	815	Pneumonia	N_2O plus O plus ether
Spinal	4	Pneumonia	N_2O plus O plus ether
		Pneumonia	Ether
		Pulmonary Embolus	Ether
		Pulmonary Embolus	Ether

In Group II a full time anesthetist has been employed by the hospital, and a record is shown of the type of anesthesia used and the chest complications. This data is not so readily available in other hospitals where in many of the cases the doctors give their own anesthetics and make no records of them.

Table 11 shows the duration of symptoms for Group I without the mortality rate, thereby having little significance, and for Group II with the mortality rate.

TABLE 11

Time	Group I Total Cases	Group II Total Cases	Deaths	Per Cent
1–24 hours	428	689	17	2.5
1– 2 days	148	230	10	4.4
2– 3 days	78	113	14	12.4
3– 4 days	54	42	5	11.9
4–21 days	214	45	0	0
Over 21 days	387	12	8	67

The mortality rate increases rapidly after forty-eight hours. In a small group in which the symptoms have been present over twenty-one days, the death rate is very high.

Table 12 shows the symptoms in acute cases.

TABLE 12

Symptoms Group II	Cases
Pain	1,172
Pain and Nausea	1,011
Tenderness	1,021
Rigidity	924

Analysis of the acute cases in this group from 1934 to 1942 shows that 315 cases out of 823 had previous attacks.

In Table 13 may be seen the postoperative complications in Group II.

TABLE 13

Complications	Cases
Peritonitis	6
Adenitis	1
Postoperative Hemorrhage	2
Measles	1
Bronchitis	7
Faecal Fistula	4
Tetanus	1
Pneumonia	6
Acidosis	1
Cystitis	2
Pyelitis	3
Pulmonary Embolus	4
Phlebitis	1
Hematoma	1
Postoperative Hernia	2
Opening of Wound	5
Abscess in Abdominal Cavity	3
Stitch Abscess	7
Bowel Obstruction	2
Pelvic Abscess	5
Paralytic Ileus	1

Table 14 shows the tabulation of the temperature and leukocyte count.

TABLE 14

WBC	Groups I and II				Total
	Temp.	No.	Temp.	No.	
4,000	98.6	4	99	11	15
5,000	98.6	28	99	17	45
6,000	98.6	50	99	49	99
7,000	98.6	41	99	45	86
8,000	98.6	56	99	79	135
9,000	98.6	42	99	62	104
10,000–15,000					453
15,000 and above					558

1,576 cases (of 3,918) had temperatures of 99 or over on admission.
767 cases (of 3,918) had temperatures of 99 or below on admission.
833 cases (of 3,918) had pulses of 100 or above on admission.

Drug Therapy

During the last four years sulfanilamide and allied drugs have been used in the treatment of appendicitis in addition to surgical treatment. Table 15 gives the mortality rate on cases receiving sulfonamide drugs from 1938 to 1942. In Group III there were no cases on record.

TABLE 15

	Year	Cases	Recovered	Deaths	Per Cent
Group I	1938	14	13	1	(There are 8 deaths and 70 cases in Group I.)
	1939	18	15	3	
	1940	22	20	2	
	1941	16	14	2	
Group II	c̄ drains	22	22	0	
	s̄ drains	17	16	1	
Total		109	100	9	8.2

In Group I there have been 70 cases of ruptured and gangrenous appendicitis in which sulfanilamide, promin, prontosil, neoprontosil, or sulfapyridine have been used as aids to surgery with eight deaths, or a mortality rate of 11 per cent. This number is small but shows a slightly lower death rate than the general mortality rate for the same class of cases in the same group. Group II, in which the drug has been used for a shorter period of time, includes 22 cases with drainage and 17 cases without drainage, a total of 39 cases with one death. This death was in a patient treated with sulfanilamide without drainage and followed disruption of the wound. There are, therefore, a total of 109 cases treated with sulfonamide drugs, and nine deaths, or a mortality rate of 8.2 per cent, which is 4 to 6 per cent lower than the general mortality rate for the series in complicated cases. This mortality rate does not compare with some of the series recently reported, but some conclusions may be drawn from the limited number of cases.

In Group I the use of sulfanilamide was started early, and in many of the cases the dose was inadequate. Several different preparations were used, and only in the very worst cases. In Group II the use of sulfanilamide was not started until the intraperitoneal method was introduced, and in this group of 39 cases with only one death, this method has been used routinely. Even with this small series, the advantage of having a high concentration of sulfanilamide in the immediate vicinity of the infection is evident.

TABLE 15-A—GROUP I

THE CAUSE OF DEATH IN PATIENTS TREATED WITH SULFONAMIDE DRUGS

Sex	Age	Duration	Type	Cause	Expiration	
M	37	Ill 2 days	Rupt. gang. app. Free pus.	Spreading peritonitis Multiple abscess.	Died 17th day.	
M	35	Missed diag. 2 days.	Rupt. abscess. Free pus. Gang. app.	General peritonitis.	Died 8th day.	
M	38	One week. Home enema	Rupt. cecum at base of app. Enema.	General peritonitis.	Died 48 hrs.	0
M	37	Less 24 hrs. Acutely ill	Retrocecal. Gang. app. No drainage.	Sulf. 48 hrs. later. Gas producing. Infection abd. wall.	Died 6th day.	0
M	45	24 hrs. Acutely ill	Gang. app. Incomplete rotation cec.	General peritonitis. Prontosil started 5th day.	Died 6th day.	0
M	47	24 hrs. Acutely ill	Rupt. gang. app. 2 enemas & ½ oz. castor oil.	Peritonitis.	Died 12th day.	
M	10	48 hrs. Acutely ill	Perf. gang. app.	General peritonitis.	Died 24 hrs.	0
M	56	24 hrs. Acutely ill.	Rupt. gang. app. 30 gr. sulf. in wound.	Pulmonary embolism.	Died 14th day.	0

In Group I during this same period, table 16 shows the mortality rate in ruptured and gangrenous cases not receiving sulfonamide drugs.

TABLE 16

Year	Cases	Deaths	Per Cent
1938	15	5	
1939	7	3	
1940	13	0	
1941	7	1	
Total	42	9	22

This mortality rate is about twice that of the group receiving sulfonamide drugs.

Table 17 shows the average number of hospital days for patients treated with sulfonamide drugs in Group I.

TABLE 17

Year	Total Days	Cases	Average Days in Hospital
1938	262	12	21
1939	283	14	20
1940	349	20	17
1941	296	18	16
Total	1,190	64	18

We must agree that the use of sulfonamide drugs lessens the complications and hospital stay in cases of ruptured and gangrenous appendicitis and will eventually lower the death rate materially.

A Plea

In conclusion, in the light of the information and experience gained, the committee in charge of the survey of appendicitis in Rock County makes a plea for the following:

1. Early diagnosis and early surgery.
2. Better histories and more complete records. A good record is a permanent photograph of your work.
3. Surgical treatment should be done by experienced and well trained men. The larger the group operating, the higher the mortality.
4. The sulfonamides are an aid in the treatment of appendicitis, but adequate drainage is still necessary in the ruptured and gangrenous cases.

Thymic Tumor in Myasthenia Gravis*

A Case Report

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Madison

ELMER HAYNES

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SINCE 1901, when Weigert[1] found at necropsy a tumor of the thymus gland in a patient who had died of myasthenia gravis, considerable literature has accumulated concerning the anatomic relationship of myasthenia gravis to thymic abnormalities. In 1917, Bell[2] reported that among fifty-six published autopsies since 1901 on cases of myasthenia gravis there were seventeen hypertrophies and ten neoplasms of the thymus. Blalock, Harvey, Ford, and Lilienthal[3] stated in 1941 that approximately 50 per cent of the necropsy reports on patients with myasthenia gravis had contained descriptions of benign tumors, hyperplasia, or persistence of the thymus. The case herewith presented was not unusual in its clinical aspects but was of interest because at autopsy a large thymic tumor was found.

Case Report

A white man, age 42, was first admitted to the hospital on April 20, 1936, with a history of diplopia and bilateral ptosis of three weeks duration. The

* Presented before the One Hundred First Annual Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1942.

family history and the past medical history were essentially negative. The physical examination was within normal limits except for a bilateral ptosis, unequal pupils, and bilateral incomplete ophthalmoplegia involving the third, fourth, and sixth cranial nerves. Spinal fluid, blood, and urine examinations were essentially normal. Roentgenograms of the skull were negative. Roentgenography of the chest was not done, since no dyspnea or percussion dullness was present. Fifteen minutes after the subcutaneous administration of 3 mg. of prostigmine and 1/150 grain of atropine sulphate, the eye symptoms disappeared. A diagnosis of myasthenia gravis was made, and the patient was placed on ephedrine and glycine. He got along very well until April, 1938, when the muscle weakness rapidly progressed so far that it seriously interfered with his work. He was then placed on a schedule of prostigmine and ephedrine and improved somewhat as long as he took the medication regularly.

On July 1, 1942, at 3:30 p.m., the patient was brought to the hospital in a semicomatose condition. The relatives gave no information about earlier admissions, diagnosis, and therapy but stressed only that he had fallen down stairs three days previously and had struck his head without losing consciousness. However, on admission he presented a picture of profound asthenia with droopy eyelids, and he was cyanotic and had difficulty in breathing and swallowing. The pulse was 120 and blood pressure 140:80. Ecchymotic areas were noted about the left eye and nose. There was a bilateral ptosis. The pupils were equal and reacted well to light; the fundi were negative. The deep reflexes were active and bilaterally equal. At 4:15 p.m., 1 mg. of prostigmine and 1/150 grain of atropine sulphate were given subcutaneously, but the patient died fifteen minutes afterwards. On questioning the family in greater detail, we obtained a history of progressive weakness beginning two weeks previously which had been accompanied by difficulty in chewing and swallowing for the last week.

An autopsy performed by Dr. John C. McCarter revealed a tumor mass 17 x 10 x 8 cm. in the mediastinum, in the region normally occupied by the thymus. The mass was encroaching on the right lung, and on the right visceral and parietal pleura were several papillomatous metastatic nodules measuring up to 0.7 cm. in size. The tumor mass was soft, gelatinous in appearance, and surrounded by a thin connective tissue capsule, and on cut section was found to contain several small cystic areas. The remainder of the gross examination revealed nothing pertinent.

On microscopic examination, the tumor mass showed proliferation of the reticulo-endothelial cells with many small areas of small lymphocytes but with very little invasive tendency. On the edge of the sections, thymic tissue which had undergone normal atrophy was noted. The striated muscle sections showed atrophy, hyaline degeneration, and patches of lymphocytic infiltration.

The thymic mass bordered between hyperplasia and tumor growth, but as lymphocytes predominated, the term "lymphoma" was preferred for the diagnosis.

Comment

During the last thirty years, various therapeutic measures have been used to influence the course of myasthenia gravis. Keschner and Strauss[4] report that more remissions occur in myasthenia gravis following roentgen therapy of the thymus than take place spontaneously. Favorable results following the surgical removal of tumors of the thymus associated with myasthenia gravis have been reported by Blalock, Mason, Morgan and Riven.[5] In 1941 Blalock, Harvey, Ford, and Lilienthal[3] reported encouraging results following extensive mediastinal exploration with removal of thymic tissue on six cases of myasthenia gravis without roentgenologic evidence of thymic enlargement.

Roentgenologic examination of the chest, including lateral views, is recommended in all cases of myasthenia gravis. However, a negative roentgenographic report does not necessarily rule out the presence of thymic enlargement. Perhaps where hypertrophy of the thymus is detected, roentgen therapy possibly followed by surgery (thymectomy) during a remission period would be the procedure of choice. Meanwhile, the symptomatic treatment of myasthenia gravis with prostigmine as outlined by Viets[6] should be strictly adhered to.

Summary

1. A case of thymic tumor associated with myasthenia gravis has been reported.

2. In addition to the thymic tumor, skeletal muscle changes were found at necropsy.

BIBLIOGRAPHY

1. Weigert, Carl: Pathologisch-anatomischer Beitrag zur Erb'schen Krankheit (Myasthenia gravis). Neurol. Centralbl. 20:597 (July) 1901.
2. Bell, E. T.: Tumors of the Thymus in Myasthenia Gravis, J. Nerv. & Ment. Dis. 45:130 (Feb.) 1917.
3. Blalock, A.; Harvey, A. M.; Ford, F. R., and Lilienthal, J. L.: The Treatment of Myasthenia Gravis by Removal of the Thymus Gland, J.A.M.A. 117: 1529 (Nov. 1) 1941.
4. Keschner, M., and Strauss, I.: Myasthenia Gravis, Arch. Neurol. & Psychiat. 17:337 (March) 1927.
5. Blalock, A.; Mason, M. F.; Morgan, H. J., and Riven, S. S.: Myasthenia Gravis and Tumors of the Thymic Region, Ann. of Surg. 110:544 (Oct.) 1939.
6. Viets, H. R.: Present Status of Myasthenia Gravis, Arch. Neurol. & Psychiat. 47:859 (May) 1942.
7. Eaton, L. M.: Myasthenia Gravis: Its Treatment and Relation to the Thymus, Proc. Staff Meet., Mayo Clin., 17:81 (Feb. 11) 1942.

Comments on Treatment

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Angina Pectoris

It is obvious that the clinical term "angina pectoris" means pain in the chest. The usual medical interpretation of the term signifies chest pains of cardiac origin and, more specifically, pain due to oxygen deprivation from heart muscle through spasm or other obstruction of the coronary vessels. Since the time of Lauder Brunton, nitrites have been used for this condition, and, more recently, the xanthine drugs, such as the theophyllines, have come into common use. An interpretation of the actions of these drugs, as well as the condition itself, has been the subject of some careful analysis.

Some years ago, D. E. Jackson proposed a radical departure from the usual interpretation of angina pectoris. On the basis of animal experimentation and a limited amount of clinical study, he came to the conclusion that the pains of angina pectoris may well arise from regions other than the heart and, in particular, from spasms of the esophagus and the cardia. Later, Kurtz and Eyster were fortunate in being able to obtain an electrocardiogram of a patient at the moment of an anginal attack, with the result that the cardiogram was identical to that known to be produced by regional hypoxia or even anoxia of the heart muscle. Rather recently, clinical evidence has been presented to the effect that gallbladder disease (spasm) may be frequently associated with pain in the chest simulating angina pectoris. Removal of the gallbladder was effective in relieving the patients of angina pectoris. All these discoveries appear to add up to the view that smooth muscle spasm of the esophagus or of the abdominal viscera initiates afferent nervous impulses which trip off efferent impulses leading to the coronaries and causing spasm therein. It might well be that pre-existing sensitivity in the coronaries exists with or without sclerosis.

Vasodilator drugs, such as members of the nitrite group, could operate on smooth muscle elsewhere, as well as on the coronaries, but obviously would be of little value in preventing recurrences.

There has been a considerable amount of work done on the xanthines (theophyllines) without much unanimity of opinion respecting either their effectiveness or mode of possible action. In a recent resumé in *The Journal of the American Medical Association,* Boyer makes an effective statement in quoting others to the effect that theophyllines may relieve angina through stimulating heart muscle to an increased output, thereby relieving the localized anemia of heart muscle. On the basis of the idea of remote or reflex causation of spasm, the xanthines could well operate by release of spasm of the gallbladder or ducts, the gastrointestinal tract, the esophagus, the coronaries, and, perhaps, smooth muscle elsewhere in heretofore unsuspected locations. Supporting these ideas comes the evidence presented by Dr. N. C. Gilbert before the Rock County Medical Society that the use of atropine significantly reduces the mortality rate in coronary abnormalities.

The famous John Hunter, who suffered from angina pectoris, is said to have expressed the view that anyone could cause his death by making him sufficiently angry. The links in the chains are now becoming more obvious; namely, powerful emotion, visceral spasm, and afferent impulses leading ultimately to reflex constriction of the coronary vessels. A. L. T.

Tuberculosis Studies in Wisconsin

Results of Four Years of Tuberculosis Control in Sanitary District No. 6, 1936-39

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THIS paper presents an analysis of the tuberculin testing and roentgenographic programs sponsored by the Wisconsin State Board of Health and local medical societies as carried out over a four year period, 1936 to 1939 inclusive, in Sanitary District Six of the Wisconsin State Board of Health, along with an analysis of active and suspicious cases of tuberculosis as recorded in the district office as of July 15, 1942, with recommendations for future activities relative to the discovery of early cases of tuberculosis.

District Six comprises the eight counties of Brown, Door, Kewaunee, Marinette, Oconto, Outagamie, Shawano, and Waupaca located in the northeastern section of the state. The 1940 census gives the total population as 322,208 distributed over an area of 6,441 square miles. The urban population is 141,391. The area is largely devoted to dairying and farming, with manufacturing and mechanical industries and trades accounting for the next largest occupational groups. About 1.5 per cent of the population is Indian. There were about 256 physicians and twenty-three public health nurses in the district at the time of this survey. All but one county employs at least one public health nurse. Two tuberculosis sanatoria are located in the district.

The Mass Tuberculin Testing Program

The program in general consisted of mass tuberculin testing of grade and high school groups as well as preschool children and adults, although more emphasis was placed on the contacts in the latter two groups.

The cooperation of the local medical society was first assured, and plans and policies were then worked out with the public relations committee of the society, generally. The financial arrangements in no two counties were the same. Payment in some counties was on a per capita basis, while in others it was on an hourly one. Appropriations were obtained from the county boards in all the counties employing public health nurses. In addition, in certain cities local funds were used to pay for isolated tuberculin testing programs or for roentgen examination.

Publicity in the form of talks, radio broadcasts, newspaper articles, placards, and essay contests preceded the distribution of the request cards authorizing the physicians to give the test. The number of requests for the tuberculin test among school children approached 70 per cent of the total number of children.

The majority of the general practitioners in the district participated in the testing program. Old tuberculin in the dilution of 1 to 1,000 furnished by the State Board of Health was used. Arrangements for roentgen examination of positive reactors varied depending upon the availability of adequate roentgenographic apparatus. In sparsely settled counties with no roentgenographic facilities or with facilities at a great distance from the positive reactors, the Wisconsin Anti-Tuberculosis Association was utilized. In one county the local tuberculosis sanatorium was utilized; in another all roentgenograms were taken at the local hospitals. Elsewhere, local physicians took the roentgenograms. The roentgenograms were

read for the most part by physicians of the W.A.T.A. In one county they were read at the sanatorium, in another by a committee of three local physicians, and in a third by the pathologists at the hospitals.

Results of Testing in District Six

Table 1 summarizes the results of the tuberculin testing program as carried out in District Six. The individuals given the tests were divided into five year age groups up to 34 years, and those over 35 were placed together. A total of 34,171 tests were given, 4,257 of which were positive, or a percentage of 12.4.

TABLE 1

TUBERCULIN TESTS BY AGE GROUPS FOR DISTRICT NO. 6

1936–1939 (Incl.)

Age Groups in Years	Total Tests		Positive Tests		Negative Tests	
	No.	% of All Tests in Age Groups	No.	% in Group Positive	No.	% in Group Negative
0– 4	327	0.9	31	9.5	296	90.5
5– 9	8,247	24.1	437	5.3	7,810	94.7
10–14	12,503	36.5	1,405	11.2	11,098	88.8
15–19	7,965	23.3	1,144	14.3	6,821	85.7
20–24	442	1.2	124	28.0	318	72.0
25–29	308	.9	125	40.5	183	59.5
30–34	318	.9	156	49.0	162	51.0
35 and Over	441	1.2	271	61.4	170	38.6
Age unknown	3,620	10.6	564	13.6	3,056	84.4
Total	34,171	100.0	4,257	12.4	29,914	87.6

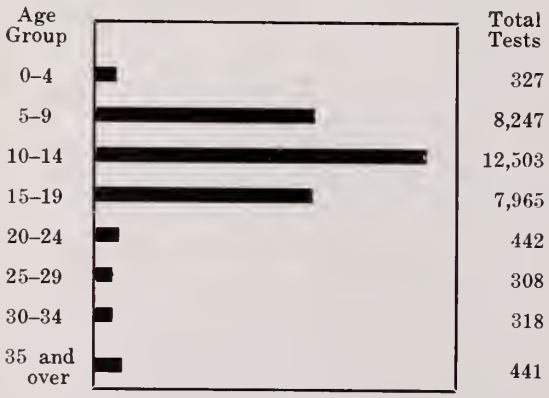

Fig. 1

Tuberculin Tests Given by Age Groups

Fig. 2

Percentage of Positive Reactors by Age Groups

Since the program was primarily one of education and was carried out in the schools, it is not surprising that the largest number of tests were given in the age group 5 to 19, as presented by figure 1. The percentage of positive reactors increases with each age group with the exception of that under 4 as shown by figure 2. The reason that the group under 4 has a higher percentage of positive reactors than the 5 to 9 group is that the children in that group did not reflect a general cross section of the district but were brought in to be tested because they were contacts of cases of tuberculosis. For that reason it is probably also true that the percentage of positive reactors in the age groups above 20 is higher in this study than is actually the case in the population as a whole. Although 60.6 per cent of all individuals tested were in the age group 5 to 14 years, only 8.8 per cent of these tests were positive; whereas, in the age group over 20 years, in which only 4.4. per cent of the tests were given, 44.8 per cent were positive.

Findings by Age Groups

Table 2 analyzes the results of the roentgenographic findings by age groups. It will be noted that there were more roentgenograms taken than there were positive reactors. This means that some individuals were roentgenographed because they had symptoms or because they were contacts and had not appeared for the tuberculin test. Only a very small number of positive reactors failed to have roentgenograms taken. Most of the roentgenograms taken of individuals who

had not received a prior tuberculin test were of individuals in the age group over 35.

Using the basis of a normal expectancy of 1 case of active tuberculosis for every 336 persons in the general population,[1] it is evident that for every 336 persons tested (table 3), the age group above 35 is the most productive for discovering active cases. This group is ten times more productive than the general population. The age group 20 to 24 is 6.5 times more productive than the normal expectancy, while the group between the ages of 25 and 34 is 8.5 times more productive than the normal expectancy. In our arriving at these figures, the questionably active cases uncovered by roentgen examination were not included. The preschool group exceeds the normal expectancy, but this is due to the fact that this group represents contacts mainly.

Referring again to table 2, it is seen that 2.9 per cent of all the roentgenograms taken were found to show active tuberculosis. This percentage seems high compared with the figure of 1 per cent which the State Board of Health recently gave for active cases found in industry.[2] However, it should be remembered that the roentgenograms used in this study were all taken on positive reactors or known contacts or individuals with symptoms pointing toward tuberculosis, while the studies in industry were made of all individuals, regardless of the tuberculin reaction.

Since both primary and reinfection type active cases are classified as "active tuberculosis," the percentage of cases found in the lowest two age groups is higher than one would normally expect. If we omit these two age groups from consideration, it is evident that the greatest percentage of cases found was in the age groups above 20, with 3.9 per cent of all roentgenograms taken showing active tuberculosis.

Roentgen Examination of Contacts Emphasized

As a result of this program and others, less emphasis is now being placed on the school groups and much more emphasis is being placed on the roentgen examination of contacts, since it is plain that therein lies the

TABLE 2

RESULTS OF ROENTGENOGRAPHIC PROGRAMS BY VARIOUS NURSING SERVICES IN DISTRICT NO. 6 1937–39 (Incl.)

Age Groups	Total Roentgenograms	ROENTGENOGRAPHIC FINDINGS											
		Active Tuberculosis		Questionable Tuberculosis		Essentially Negative		Healed Reinfection		Healed Primary Inf.		Non-Tb. Condition	
		No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
0– 4	58	2	3.4	2	3.4	38	65.5	0	0	15	25.9	4	6.9
5– 9	358	18	5.0	5	1.3	198	55.3	7	1.9	128	35.7	40	11.1
10–14	1136	31	2.7	19	1.7	684	60.2	19	1.7	371	32.7	92	8.09
15–19	1481	21	1.41	19	1.3	868	58.6	29	1.9	551	37.2	57	3.8
20–24	244	11	4.5	13	5.3	154	63.1	3	1.2	60	24.5	9	3.7
25–29	248	11	4.4	11	4.4	139	56.0	26	10.4	63	25.4	11	4.4
30–34	283	11	3.9	10	3.5	157	55.4	31	10.9	75	26.5	21	7.4
35 and Over	837	30	3.6	31	3.7	406	48.5	85	10.1	258	30.8	110	13.1
Total	4645	135	2.9	110	2.4	2644	56.9	200	4.3	1521	32.7	344	7.4

TABLE 3

COMPARISON OF CASES EXPECTED AND CASES FOUND BY AGE GROUPS

Age Group	No. of Tests or Individuals Examined	No. Cases per 336 Persons Examined Expected to be Active	No. Active Cases Actually Discovered	No. of Times Normal Expectancy Is Exceeded
0– 4	354	1.0	2	2.0
5– 9	8,247	24.5	18	0.73
10–14	12,503	37.2	31	0.83
15–19	8,302	24.7	21	0.85
20–24	562	1.7	11	6.5
25–29	431	1.3	11	8.5
30–34	445	1.3	11	8.5
35 and Over	1,002	3.0	30	10.0
All Ages	35,466	105.5	135	1.3

most fertile field for discovering active cases of tuberculosis.

More physicians are today referring patients to the centers where they may receive a tuberculin test and roentgen examination than ever before. The result of the test and the roentgenographic findings are then sent to the patient's own physician, who again continues to handle the case.

For the past few years a tuberculosis register has been kept in each district office, permitting a visualization of the problem as it exists at any one time and enabling proper emphasis to be placed on areas needing the most work. Table 4 gives an analysis of the active and suspicious cases in the register by counties along with the death rate for the three year period, 1938–40, and the estimated number of cases. The estimate[2] was arrived at by multiplying the three year (1938–1940) average of deaths by eighteen, since it has been estimated that the probable number of active cases of tuberculosis is approximately double the number obtained by the Framingham study of 9 cases per each annual death. It can be more readily believed that the Framingham ratio underestimates the number of active cases when reference is made to table 4. Marinette County is actually credited with 81 known cases of active tuberculosis. If the Framingham ratio applied, there should be 78 cases, and we would have to assume that all active cases in that county were already known. Actually, it is very doubtful that all cases are known, and our estimate that only 51.6 per cent of the cases are known is much more likely to be correct. The percent of estimated cases known varies from 22.8 to 65.3. It may be assumed that there exist in the district 760 cases of active tuberculosis still to be discovered.

Only one county in this district has a tuberculosis death rate higher than the state average.

In general, counties having high death rates also show a low percentage of known cases registered.

Of the 330 definitely active cases, only 44 are in the minimal stage. Subtracting the 35 undetermined cases from the total, the district has 14.9 per cent of its cases in the minimal stage of the disease. If the physicians will take the proper interest in the 124 sus-

TABLE 4

ANALYSIS OF ACTIVE AND SUSPICIOUS TUBERCULOSIS CASES

Recorded in District Tuberculosis Register as of July 15, 1942

Political Division	T. B. Death Rate for 3-Yr. Period 1938-40	Estimated Number of Cases.[1]	Total Cases Known	No. of Cases Still to Discover	Percent of Estimated Cases Known	Active Cases					Suspicious Cases		
						Undetermined and Others	Minimal	Moderately Advanced	Far Advanced	Total	Selective Service	Other	
Brown	18	265	116	149	43.8	9	16	22	49	96	12	8	20
Door	14	49	32	17	65.3	5	0	8	7	20	9	3	12
Kewaunee	22	67	25	42	37.3	1	2	7	8	18	7	0	7
Marinette	24	157	81	76	51.6	4	6	18	22	50	9	22	31
Oconto	23	113	41	72	36.3	2	5	6	6	19	6	16	22
Outagamie	16	203	68	135	33.5	4	10	26	18	58	5	5	10
Shawano[2]	30	193	53	140	27.5	6	5	13	15	39	6	0	6
Men. Ind. Res.			17			3	0	2	4	9	8	0	8
Waupaca	27	167	38	129	22.8	4	0	17	9	30	7	1	8
State Total	27.1	1214	454	760	37.4	35	44	117	134	330	69	55	124

[1] Estimate based on bibliographic reference 2, in which it is stated that the probable number of cases is approximately double the number obtained by the Framingham study of 9 cases per each annual death.

[2] County figures include those for Menominee Indian Reservation.

picious cases known, it should be possible to increase the percentage of minimal cases, as undoubtedly many of these are minimal active cases, while the remaining number are probably arrested.

Increase in Tuberculosis Imminent

With the shortage of physicians and public health nurses, which shortage may be expected to become more acute, and with the expected increase in cases of tuberculosis as a result of mass migrations, crowded housing conditions, overwork, and other factors, it becomes apparent that future programs of tuberculosis control should be so developed as to conserve the physicians' and nurses' time and yet result in the greatest benefit to public health.

This study bears out what others have said relative to the promiscuous tuberculin testing of school children.[3] It can be condemned as a waste of time, money, and effort as far as discovering active cases of tuberculosis is concerned. From an educational point of view, other methods of educating the school child will prove just as satisfactory, if not more so, and will be much less expensive.

The periodic examination of contacts of an infected patient is the most fertile field for discovering new cases. Roentgen examination of all contacts periodically for the duration of their lives, however, would be a tremendous undertaking in itself. Eight years of experience at the Middlesex County Sanatorium has led to a certain schedule of examinations.[4]

A Suggested Program Involving Contacts

Combining the lessons obtained from this experience with that of District Six, the following program involving contacts might be inaugurated, assuming that the contact with the case of tuberculosis is broken at the time of discovery:

1. Infants under 3 years of age are to have a tuberculin test. If the reaction is positive, a chest roentgenogram would be taken. If the reaction is negative, the test would be repeated at six month intervals for a period of two years.

2. Children 3 to 14 years old, if negative to the tuberculin test on the first examination, are listed for re-examination when 12 and 14 years of age and are then until 20 years of age subjected to annual tests or roentgen examinations.

3. Adolescents, 15 years of age or over when first examined, are to be subjected to annual roentgenography until they are 25 years old, regardless of the result of the tuberculin test.

4. Adults who are between the ages of 25 and 35 when first examined are to be subjected to semi-annual roentgen examination for two more years.

5. Any adult over 35 years of age at the time of the first visit is to be discharged if his roentgenogram shows no evidence of pulmonary disease at termination of one year of observation.

The above described program of contact examination would require the close cooperation of the private physicians with the local public health agency and vice versa.

Summary

This paper presents an analysis of tuberculin testing and roentgen examination programs carried out in Sanitary District Six during the years 1936 to 1939, inclusive.

The age groups above 20 provide the most fertile field for the discovery of active cases of tuberculosis.

Tuberculin testing of school children, especially grade school children, as a means of discovering cases of active tuberculosis should be discontinued in favor of more work directed toward the examination of contacts. A program for this contact examination is presented.

It is estimated that almost 800 cases of active tuberculosis are still undiscovered in the district.

BIBLIOGRAPHY

1. Morse, L. M.: Control of Tuberculosis in Wisconsin, J.A.M.A. 116:2142 (May 10) 1941.
2. Jorris, E. H.: War and the Tuberculosis Problem, Wisconsin State Board of Health Quarterly Bulletin 7:15 (Jan.–Mar.) 1942.
3. Godfrey, E. S., Jr.: What Principles Should Guide the Program of Tuberculosis Associations in the Light of Its Epidemiology? Nat. Tuberc. A. Tr. 3:137, 1940.
4. Chadwick, H. D., and Pope, A. S.: The Modern Attack on Tuberculosis, New York, The Commonwealth Fund, 1942, p. 76.

Estimation of Disability in Compensation Cases*

By CHESTER C. SCHNEIDER, M. D.
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MANAGEMENT of industrial injury cases by the physician entails a responsibility not present in ordinary doctor-patient relationships in that the rights of all parties involved in the matter, as well as those of the patient, must be recognized and respected. In addition to the basic requirement of providing a high type of medical care to the injured, there is the matter of appraising the exact period during which the patient is totally unable to engage in readily available employment, the period in which he is able to engage in only limited periods or types of employment, and finally the extent of disability which will ultimately be present after all therapeutic and natural influences have been exhausted in achieving a cure.

The Physician's Judgment

The first two of these require reasonably frequent and careful observation of the patient during his convalescence so that the physical aspects of the case can adequately be comprehrended to determine when the special therapeutic measures being employed are no longer of sufficient value to warrant their continuation or when purposeful activity will be more effective than medical therapy in rehabilitating the patient. It is essential that the physician, rather than the patient, make this decision, because the conclusions of the physician in this respect can obviously be based upon sounder judgment than would those of the patient. The experience of the physician with the exact nature of the injury being treated, his knowledge of the potential dangers to be encountered in the further convalescence, and his complete detachment from all extraneous influences upon his judgment should impose upon him the responsibility of determining when the patient should return to work and how much and what kind of work he shall do. If decisions of this kind are left to the patient, serious errors will necessarily result due to the innumerable collateral forces which influence his judgment. Great patience, sympathetic encouragement, and a thorough understanding of the patient, his physical condition, the environmental influences which play upon him, and the character of his employment must be exhibited by the physician if he would succeed in discharging his full responsibilities to all concerned under the Industrial Act.

Finally, after the patient has been restored to employment or has recovered as completely as may reasonably be anticipated, the question of appraising the permanent disability resulting from his injuries must be undertaken. While experience in this field is a valuable asset to any physician embarking on this adventure, it is not necessarily indispensable if the matter is approached in a careful manner taking certain fundamental aspects of the situation into consideration.

Rules of Action

A few rules of action based upon a rather large experience in this field may be helpful to those who are not familiar with the art:

1. *Completely detach yourself from any personal consideration toward anyone involved in the matter.*

The injured may be a friend, a relative, an old patient, an influential person, or

* Presented before the One Hundred First Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1942.

someone else whom you would like to favor, or he may be an ingrate, a reprobate, a malingerer, or chronic complainer for whom you may have little compassion. Through persuasion or other means, other interested individuals may undertake to influence your judgment. Disregard all these in estimating the disability, and let your conclusions rest entirely upon specific evidence.

2. *Thoroughly familiarize yourself with all aspects of the case using as a basis a complete examination of the patient* so that not only the effects of the recent injury are well known to you but also the general physical condition of the patient, including the consequences of old injuries or existing disease. Some physicians are prone to jump to a conclusion in broad general terms based upon allegations rather than findings, apparently little aware that subjective complaints usually occupy a relatively minor position in relation to the objective picture. All this evidence should be set forth in a logical manner so that it may be appraised in comparison with certain definitely established disabilities recognized in industrial practice. In this connection, every physician should have available a copy of the most recent edition of the Wisconsin Industrial Act and the table of disabilities for specific defects employed by the Industrial Commission of this state in evaluating disabilities. If the physician then establishes his conclusions on the basis of objective findings and subjective complaints in relation to the fixed tables of the Industrial Commission, his estimate of disability is not likely to be seriously wrong.

It should constantly be borne in mind that estimates of disability in Wisconsin refer to the man as a complete unit for all types of work and do not relate to the individual's capacity for the performance of any particular job. Thus, to take a simple example, the loss of 50 per cent motion at the right shoulder has the same compensable value for a violinist as it has for a night watchman, even though it might prevent the former from continuing at the employment for which he was trained and would in no way interfere with the duties of the latter. While such a practice might occasionally reflect to the disadvantage of individuals in certain types of employment, its fairness as a general provision has been well established throughout the period of its use.

3. *Evaluate subjective complaints on the basis of your experience with similar cases in private practice* rather than on the dramatic prowess of the patient at hand.

While it is only fair to recognize the different thresholds for pain among injured individuals, attention should continually be directed to the sincerity of the patient, the consistency of his allegations, his manner of speech, disposition, suggestibility, cooperativeness, and other characteristics.

Three Stages in a Patient's Reactions

I have repeatedly noted three major stages in a patient's reactions to his injuries and treatment. The first occurs during the early phases of his convalescence when he is appreciative of the relief which the physician's ministrations have afforded him. During this phase he recognizes the progress which he is making, favorably appraises the doctor's every effort in his behalf, cooperates in his convalescence, and readily acknowledges the relief from subjective symptoms and functional impairment which he is experiencing. During this phase there is no conflict between his interests and the physician's aims; therefore, the doctor is his friend, and all is well.

Unfortunately, this happy situation sooner or later changes, because eventually the healing period ends, the part time light work is replaced by full time regular work, and the patient becomes conscious of his remaining defects (whatever they may be) in their effect upon his ability to carry on. At this point some resentment toward his employer, his immediate superiors on the job, or possibly fellow-workers who caused his injury begins to develop, and there may even be a suspicion that he did not make as complete a recovery as he should have. This attitude of mind soon reflects itself in his efficiency, and difficulties with his job and associates arise. This leads to a state of more or less dissatisfaction with practically everything and everyone with whom he has dealt since he was hurt and is frequently nurtured by friends, relatives, and fellow employees.

The patient is out to get recompense for what he has suffered, and he looks to his physician to take up the cudgels in his behalf. But at this point, the physician appears too coldly objective to suit him, he does not share the patient's sudden change of heart, and is more bent on rehabilitating the patient than rewarding him for his trouble. So the whole doctor-patient relationship changes. All kinds of new symptoms creep back into the picture, and, try as the doctor may to assuage them, they persist with increasing variety and vigor.

The doctor is no longer the trusted friend; he cannot go all out for the patient in his new guise, and eventually estrangement of the two ensues. The doctor is now out, and the medicolegal battle is on. A lawyer and new doctors enter the scene, a hearing is scheduled before the Commission, and the treating physician is an outcast. How often have many of us appeared at Commission hearings to learn what scoundrels we have been! Our kindly ministrations to the sick and injured were devices of the devil, our surgical skill and zeal not only failed to improve but made the patient worse, long before he was able to leave the hospital he was thrown out, and finally he was forced to work before he could even reach the job, much less perform it. But, with all the abuse, the record usually suffices to establish the humanitarianism of our efforts, and ere long the award comes through, and the case is closed. Forthwith, the ills of the patient rapidly diminish, his adaptation to his environment improves, and he has forgotten the petty and ulterior impulses which motivated him. To his surprise, he can again carry on as you had told him he would, and he gradually recognizes that you were his friend after all.

This ushers in phase three when gratitude returns and the patient may even reappear with a fellow workman or a member of his family who has been injured, or in some other way he expresses his appreciation for what you have done. Often months or years later he may even return as a patient himself, ready to go through the same process all over again.

"We Are Physicians . . ."

And so it all leads to the proposition that in our work under the aegis of the Wisconsin Industrial Act, we must not forget that we are physicians whose fundamental and primary duty is to relieve the sick and injured, to respect the rights of all concerned, to be thorough in our work, unprejudiced in our conclusions, and conscientious in our every act. Under these conditions even industrial practice can be gratifying.

DO YOU NEED BATTERIES?

As a service to members of the Society, arrangements have been made to secure a supply of flashlight batteries for use by physicians in the discharge of their professional duties. Virtually the entire output of the battery manufacturers is assigned to military orders. A part of the small amount allocated for civilian use has been made available by the Ray-o-Vac Company for distribution to physicians without profit to the Society. The management of the Ray-o-Vac Company recognizes the essentiality of using batteries in the physician's practice.

If you need batteries for your otoscope, opthalmoscope, or for flashlights used in other examining instruments, fill in the order blank below and forward it to the Society's office:

Mr. C. H. Crownhart, Secretary
State Medical Society of Wisconsin
917 Tenney Building
Madison (3), Wisconsin

Please enter my order for the following batteries which will be used by me for diagnostic or treatment purposes.

Penlight Batteries (7R) _____ _____
Quantity

Standard No. 2 Size _____ _____
Quantity

_____ M. D.

_____ Address

The Nation at War

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Death From Wounds in Services Held to 3 Per Cent

The *Wautoma Argus* in its issue of June 17, 1943, summarizes a report by the Office of War Information on the medical care system of the Army and the Navy and its effectiveness in reducing the number of fatalities from wounds.

Announcement that more than 97 per cent of naval and marine wounded from Pearl Harbor to March 31, 1943, have recovered was made today by the Office of War Information. These figures were contained in a report by OWI on the care of the wounded by the medical departments of the army and navy.

Percentage figures for the recovery of Army wounded are not available at present owing to incompleteness of records from the fighting fronts. An analysis of the available data on army wounded shows that recoveries are comparable to naval and marine percentages.

Of all navy and marine personnel wounded only 2.6 per cent died subsequently. Fifty-three per cent were returned to duty. Still under treatment as of March 31 were 43.5 per cent. Invalided from service were 0.9 per cent.

In the original occupation of North Africa, the only deaths were those of men killed outright or so badly wounded that nothing could have saved them. This was also true in other theatres of war.

Never before in the history of the world has the fighting man had available the medical care and equipment the United States now furnishes its defenders. When medical supplies are delayed in reaching the front—and not even the Red Cross can stop a bomb, as the Nazis and Japs know well—our doctors are trained to perform their duties with whatever equipment is at hand. In the North African campaign, ships carrying medical material were torpedoed. Yet our medical care system was established right from the beaches of the Mediterranean, and the hundreds of recoveries from the wounds testify to its effectiveness.

To understand how this mercy system works, we must start with the soldier himself. Each man has fastened to his belt, easily removable, a first-aid packet, a package of sulfadiazine tablets—an improved member of the sulfa family of drugs—and sulfa powder. These sulfa drugs are the marvel of medical science which have conquered some of our most virulent foes—blood diseases, infections and pneumonia.

If the soldier is conscious, he begins to take the sulfa tablets as soon as he is hurt. The special package releases them into his hand one at a time. He dusts the sulfa powder into his wound. He uses the first-aid packet.

In all probability, however, a hospital corpsman has reached him before he has a chance to do this. The number of corpsmen to any group of enlisted men has been worked out through long experience by the medical corps.

The corpsman has a larger kit of supplies with him and administers quickly to the soldier giving him an injection of a drug which stops pain almost instantly. He does not remain with the fallen soldier, as he has to move forward with the attack. After treatment he ties a tag to the soldier's belt telling what type of treatment was administered, fixing a bit of gauze to a bayonet or a stick to mark the place where the soldier is.

Now come the litter-bearers, attracted by the white cloth. They carry the soldier to a battalion aid station from 400 to 1,000 yards back. This station, a miniature hospital on wheels which goes wherever the soldier goes, is staffed by two physicians and assistants and has operating instruments, anesthetics, sulfanilamide, opiates to relieve pain, hot drinks, and, most important, blood plasma to combat shock and loss of blood.

The Battalion Aid Station

The battalion aid station may be compared to the emergency room in an ordinary hospital. Here the soldier receives treatment which will keep him comfortable until he is removed still farther back. Just as in the hospital emergency room, speed of treatment is all-important. The battalion aid station provides swift, expert, life-saving treatment and surgery.

In the usual case the soldier remains here a day or less, and then is evacuated by ambulance-jeep or other conveyance back to the collecting station, as he would be taken from the emergency room of a hospital to a ward for further treatment. This, too, is mobile, and can be brought up as close to the front line as necessary. Here the various cases are classified so that each man is assured of the exact type of treatment required for his particular injury. A complete record of the injury is made here, with recommendations of the doctors who have examined

and treated the soldier. Nothing is left to chance. The charts and orders of the physicians are as carefully maintained as in a large city hospital. At these collecting stations are a number of ambulances and other conveyances for getting the injured to them quickly. There are always enough collecting stations so that one can be kept in reserve, to be used if the number of injured suddenly increases.

From the collecting stations, the more seriously wounded are evacuated to field hospitals or evacuation hospitals, after going through a clearing station. These are usually some five to seven miles back of the battle line, although, being highly mobile, they can be brought right up to the front. These field hospitals travel on six wheels, four of them with double tires to permit rapid movement over rough ground. They are ready for instant use, and a major operation can be performed in one of these hospitals a few minutes after a man is wounded. These units are equipped with the most modern medical and surgical supplies and are staffed by expert surgeons. A more advanced type of emergency surgery is practiced here, with specialists available for all kinds of injuries. Yet even these units, complete as they are, are but way stations which prepare the soldier for further treatment—a part of our hospital chain which extends half-way around the world.

The Base Hospital

Farthest back are the great general, or base, hospitals. These are not mobile. They are far removed from the battle area, sometimes several hundred miles. The wounded are brought to them by ambulance or ambulance plane—those specially equipped air transports which were developed under the direction of the air surgeon. The general hospitals have 1,000 beds or more, and are the equal of the most elaborate city hospitals. The men may remain there until they are entirely cured and returned to duty, or they may be sent back to general and convalescent hospitals in the United States—huge, well equipped and staffed institutions maintained in various parts of the country by the Army and Navy.

Often the trip to the home hospital is made by ambulance plane. There have been cases of men wounded on some distant battlefield several thousand miles away reaching this country faster than the report of their wounding; of a cheerful "Hi, Mom!" over long-distance telephone informing a mother of her son's safe return.

One soldier with a severe abdominal wound was brought by ambulance plane from Egypt in 72 hours and is now recovering rapidly in an army hospital. Others have been flown from the Far East, Europe, India, Africa. The fact that a man knows he can be home in a couple of days from almost any part of the world is a tremendous morale-builder.

Flexibility of Mercy System

These methods of treatment of wounded and evacuating them from battle areas—the whole mercy system of the United States medical departments—must be extremely flexible. In this war there are no rigid and distinct battle lines. A front may be on a beach, in a jungle, on the edge of a desert, or the bank of a river. It can change in an hour. Our medical care organization must be ready to make a change. Any system which depends upon inflexible regulation for its effectiveness is useless. That is why our medical officers are trained to adapt themselves to all conditions. That is the reason for our mobile hospital units.

One of these mobile units, to which many a soldier owes his life, is the mobile X-ray machine. In the last war, these machines, although technically portable, were huge, clumsy affairs; several men were required to haul them from one room to another. The present battlefield X-ray unit can literally go into action with the men. Composed of sections which are easily taken apart and put together, it can be assembled, including the dark room, in thirty minutes. Built so compactly that it can be fitted into three small trunks, it weighs only 399 pounds and can be brought by auto or jeep right up to the front line.

The Portable X-Ray Unit

There is no longer any need to wait until a soldier can reach a base hospital before X-ray pictures can be taken of his injury. This can be done now an hour or so after the wound is incurred, and treatment begun immediately. The portable X-ray machine is a product of the army medical school. Besides taking X-ray pictures, it also has a fluoroscopic screen through which the physician can examine hidden injuries. By means of this screen the physician can locate a foreign body, such as a bullet, within a minute after the wounded man is placed under the machine.

There is also a mobile bacteriologic laboratory. In this laboratory tests can be made to determine immediately whether water is fit to drink, the nature of any disease which may attack the troops, the purity of food products. It is a miniature health department on wheels and contributes greatly toward keeping our fighting men in perfect health, wherever they may be.

The traveling optical laboratory is one of the newest and most interesting of our mobile field units. Following the soldier to the field of action, it can supply practically all types of lenses for eyeglasses. Thus if a soldier who wears glasses loses them or they are shattered, he is not compelled to wait days, or weeks, to get to an optician for new ones. The optician is right at hand, and in a few hours the soldier is fitted with the proper glasses, ready to return to duty. In the last war a soldier who lost his glasses was incapacitated for several days or more. Now this cannot happen. Like other units, it is part of the huge army mobile supply depot, which supplies everything from blankets to surgical instruments, and which maintains constant contact with the front line troops.

There is even a mobile dental unit. It has an easily moved dental chair and all equipment necessary to care for the teeth of our fighters.

Mobile Water-Purifiers

The problem of contaminated drinking water has been solved by the use of mobile water-purifiers. These extraordinary machines go with troops into foreign territory, and all water drunk by U. S. forces—regardless of any guarantee that it is harmless—is put through a purifier. Thus every man is assured of water as good as he gets at home.

For use in transferring wounded men from evacuation points to base hospitals abroad there is the ambulance train, the first of which was very recently turned over to us by the British under lend-lease—which works both ways. These trains have six ward cars; a car for sitting-up patients; a pharmacy car and other cars for storing materiel; and medical officers, nurses and attendants. They have operating rooms, special compartments for psychiatric cases and flexible, sterile beds with ash trays and electric fans beside them. The trains carry—in addition to medical personnel—electricians, plumbers, carpenters and have special dynamos which provide electricity for light and heat. They can run on English, French and some Russian tracks. These trains are not yet equipped to run on tracks in North Africa.

The Sulfa Drugs and Blood Plasma

Much has been written about those wonder discoveries of modern medicine—the sulfa drugs and blood substitutes, notably plasma. They have, in truth, revolutionized our treatment of the wounded. Sulfa has not only saved thousand of lives, it also prevents infection and thus has greatly reduced amputations. Plasma—the liquid part of the blood which, through processing, can be dried and carried in small packages, is instantly available for use on fields of action. Easily administered, it literally keeps death from the wounded. When 400 soldiers were burned by flaming oil in the North African occupation, plasma and speed of treatment saved the lives of all but six. Our armed forces have great quantities of this lifesaver, and public spirited citizens are daily contributing blood for more of it. It can be kept for five years or more in dehydrated powdered form or in hermetically sealed bottles. No refrigeration is necessary, nor is it affected by jolting.

Month after month of work, research and experiment have gone into the development of our army and navy medical equipment. This has resulted in such inventions as folding litters and folding legs and arm splints, which may be packed in small spaces for use in battle areas; the jungle kit, carried by men on duty in the tropics, containing apparatus for counteracting snakebite, various kinds of drugs from aspirin to atabrine (for malaria), salt tablets to prevent the heat cramps, and a liquid which, spread on the skin, keeps insects away; the arctic kit for troops in northern countries, with materials for the prevention and cure of freezing and frost bite, and "multi-vitamins," to keep a man healthy and strong, even on limited rations.

The new type of hypodermic used on fields of action to block severe pain is marvelously simple and speedy to operate. It carries its own drug and is already sterilized for instant use.

"The Medical Department in Amphibious Assault," a film to be presented at the Annual Meeting, demonstrates many aspects of the medical care described in the foregoing reprint.

Military Notes

A letter from **Lieutenant James J. Gaunt**, Milwaukee, now stationed at Camp Joseph H. Pendleton, Oceanside, California, is of additional interest in that it contains references to many other Wisconsin physicians. He writes as follows: "It is with a great deal of pleasure that I receive your news letters and official publications of the Society. I am very grateful for all the correspondence I am receiving and certainly enjoy the news of the activities at home and also of my colleagues in the service.

"Last Sunday I bumped into **Dr. John Hirschboeck** [Lieutenant; formerly of Milwaukee] and his bride, the former Rosemary Bach, at the Mission San Luis Rey near Oceanside, California. He is at the U. S. Naval Training Station at San Diego with **Dr. (Commander) J. C. Sargent** and **Dr. (Lieutenant Commander) Jack Mulsow** [both formerly of Milwaukee.]

"I came on active duty in the U. S. Naval Reserve as a Lieutenant (j.g.) on September 7, 1942. My first duty was at the U. S. Naval Hospital, Bethesda, Maryland. There I studied tropical medicine for three months. At that school were also **Drs. Jim Conway** [Lieutenant Commander] and **Jack Kinsey** [Lieutenant Commander] of Milwaukee, **Dr. P. E. Campbell** [Lieutenant] of Waukesha, and **Dr. Jim Vedder** [Lieutenant] of Marshfield. In December I was transferred to the Marine Corps and stationed at New River, N. C., until March of this year, when I was transferred to Camp Joseph H. Pendleton in Oceanside, California.

"On December 19, 1942, I became the proud father of a baby girl. My wife is the former Alice Mary Bruce of Milwaukee.

"I think I speak for all of the boys in service when I say that all we ask of you at home is to keep the profession up to the standards it maintained when we left and make it a worthwhile thing to come home to and don't let us have to put up with socialized medicine when we do return."

* * *

Captain David Wigod writes from somewhere in England that even though he is a long way from his home in Waterford, he is anxious to know what goes on in his home state.

The Station Hospital, Jefferson Barracks, Missouri, is the present location of **Lieutenant Francis M. Hauch**, formerly of Kaukauna. Lieutenant Hauch recently was graduated from the Medical Field Service School at Carlisle Barracks, Pennsylvania.

* * *

The following are the assignments given Racine physicians who recently left for the service: **Lieutenant Commander R. W. Kreul**, U. S. Navy, Mare Island, San Francisco, California, July 29; **Captain Leo Lifschutz**, U. S. Army, Barns Hospital, Vancouver, Washington, July 29; **Captain Samuel Faber**, U. S. Army, Vancouver Barracks, Washington, July 25.

* * *

August 9 is the date when **Lieutenant David D. Ruehlman**, Monroe, reported for active duty with the United States Navy. Lieutenant Ruehlman was formerly a physician in Monroe, where Mrs. Ruehlman and the two children will continue to reside.

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Writing from a "spot in the Pacific," **Captain B. A. Ruskin**, formerly of Wauwatosa, calls news from home the greatest morale builder which men in the service have and expresses his gratefulness for the circular letters and the issues of *The Journal.*

* * *

According to a V-Mail message from **Captain John M. Usow**, psychiatry is playing an important role in the work of physicians now in service.

Captain Usow writes as follows: "Recently I received the *Journals* of January, February, and March, together with your news letter, all of which were graciously received, although somewhat belated. Your news letter is a fine innovation, and I reviewed it with interest as it seemed to bring me back to something which it seemed was very remote, my own Medical Society and my old friends.

"I've been in French North Africa for some time now, but I've met very few medical men from Wisconsin. It seems they've all gone west to fight the Japs. Leonard Schwade of Milwaukee and **Dr. Geist** [Captain Frederick D. Geist] of Madison are about the only Wisconsinites I've even heard of being in this area. I was the only neuropsychiatrist in this area for some time; however, recently my load was somewhat relieved when Dr. Roy Grinker of Chicago was assigned to aid me. I read many volumes about the part psychiatry played in World War I; however, I feel that it is even more important this time. We are close enough to the fighting front to see war neuroses shortly after they are precipitated, and I assure you they present an interesting study. Aside from war neurosis, we have seen the whole gamut of psychiatric material from malingering to actual psychosis. We are in close cooperation with several British General Hospitals where some of our American patients are confined, and it gives us a greater perspective as to how other people do things. The rest of our staff is equally busy, and the boys all seem happy to be doing the things they wanted to do and having plenty of it.

"I assure you I will appreciate any communications you have to offer relative to the activities of the Society and my friends."

* * *

The Air Force Basic Training Center at Atlantic City, New Jersey, is the assignmnet of both **Lieutenant Harvey G. E. Mallow**, Watertown, and **Lieutenant Harlan M. Levin**, Darien. Both physicians entered military service on June 3, 1943, and had six weeks of temporary duty at Carlisle Barracks, Pennsylvania.

* * *

Promotion from the rank of major is the honor recently bestowed upon **Lieutenant Colonel Walter T. Becker**, Milwaukee, now serving in New Guinea. Lieutenant Colonel Becker joined the service as a captain and, after eleven months, was promoted to major. He has been in the South Pacific theater in Australia and New Guinea for a year and a half. Prior to his location in Milwaukee as a practicing physician, he practiced in Mosinee.

Mrs. Becker and the two children are residing for the duration at the home of Mrs. Becker's mother in Cedarburg.

* * *

Captain W. F. Lappley, Madison, who is now overseas with the United States Army, writes that his unit landed in North Africa to the tune of a band playing "Over There": "I am having some unusual experiences, but since censorship is very rigid, I cannot talk the way I would like to. The trip over was interesting but uneventful. I find ocean travel monotonous especially on a troop transport.

"This is an interesting country with its mixture of peoples from all over. The American Army is very much in evidence. The landscape is beautiful and green, and there are fig orchards and date trees scattered about.

"The climate is rather pleasant and not nearly as hot as I expected it to be. The evenings are always rather cool, and we sleep under blankets.

"The population is a mixture of French and Moors, or Moslems, whichever you want to call them. The French are much like Americans in dress and habits, and many of them can speak some English.

"The natives have their peculiar voluminously colorful garbs and their habits and customs seem most unusual to us. They also speak French, so we do have to learn their most perplexing language. I have learned some French already, but I'm still unable to carry on a conversation to any extent."

Before practicing in Madison, Captain Lappley practiced in Black Earth and Cross Plains.

* * *

Lieutenant Francis L. O'Keefe is the first professional man from Delavan to give his services to the United States Navy in World War II. He reported for duty at San Diego, California, on July 5. Mrs. O'Keefe accompanied him to his station.

Lieutenant Joseph F. Kelley, formerly of Janesville, places *The Wisconsin Medical Journal* next in importance to his home town newspaper and says that he reads it through and through. Lieutenant Kelley is now stationed at Tullahoma, Tennessee. Previously, he had been stationed in Florida and later at Randolph Field, Texas.

* * *

According to a letter received recently from **Lieutenant Colonel S. W. Hollenbeck**, formerly of Milwaukee, he has had malaria on three different occasions and feels that he has some first-hand knowledge on tropical diseases. He is at present commanding a medical batallion.

Complimenting the efforts of physicians in service, he says, ". . . believe me, when the going is toughest, the medics come forth with their best efforts. They did a great job, and they will continue to do so."

* * *

From "Somewhere in New Guinea" comes a message from **Captain R. L. Waffle**, Fond du Lac, who claims that *The Wisconsin Medical Journal* is a bright spot in the week whenever it reaches him and that the news letters are of special interest in that they keep the men in service informed as to what is going on in the medical circles at home.

Telling of his assignment and the demands upon the medical profession as peculiar to the locality where he is, he writes: "We have all kinds of tropical diseases here—many of which were just 'names to be forgotten' when I was in medical school. However, malaria, dysentary, and typhus are our biggest problems, and I think we are doing a good job in coping with them. Skin diseases of all kinds are very prevalent here, and a dermatologist is really in his glory. The only trouble is that healing of all kinds seems to be very slow in this climate, and skin lesions are no exception to the rule.

"Our weather continues to be very warm, despite the fact that fall and winter are coming on down here. However, the nights are cool, and they make for nice sleeping. Recently we have been having some very strong winds, and many are the times I have thought my tent would blow away. The moon has also been full, and as usual it has attracted our usual crop of 'visitors.' One of our open air movies was interrupted three times last week, and there were fireworks each time. Some fun!"

* * *

Promotion from the rank of lieutenant colonel is the distinction recently bestowed upon **Colonel Carl S. Williamson**, who is at present the commanding officer of a station hospital at a Caribbean Army air base. Colonel Williamson began active duty with the rank of major on January 1, 1941, after practicing thirteen years in Green Bay.

* * *

Major Louis B. McBain, whose present assignment is Camp Chaffee, Arkansas, informs us that he left the 395th Engineering Batallion at Fort Knox, Kentucky, on May 1 and attended the 14th Special Cadre Course at Carlisle Barracks, Pennsylvania, during the month of May. He reported as regimental surgeon to the 476th Armored Infantry Regiment of the 16th Armored Division at Camp Chaffee on June 9.

* * *

Major Carlton S. Bolles, former De Pere physician, is stationed at Camp Wolters, Texas, at the infantry replacement training center as chief of the dermatology and allergy clinics. He has been at Camp Wolters during the last two years. Mrs. Bolles and their two children reside with him at Mineral Wells, Texas.

* * *

Captain Gunnar D. Quisling, Madison, is now located at Camp Butner, North Carolina, having been transferred in July from Camp Stewart, Georgia, where he was head of the eye clinic. Since beginning his new assignment, he has appeared on the "We the People" program of the Columbia Broadcasting System. Being a cousin of the Benedict Arnold of Norway, Vidkun Quisling, and having visited his cousin in Norway in 1931, Captain Quisling spoke on the Norwegian Quisling's development into a Nazi tool.

Captain Quisling recently contributed two secret inventions to the United States government and is now working on a third invention.

* * *

Captain David Twohig, formerly of Fond du Lac and now of our armed forces, is getting the *Journal* each month and enjoys each issue more as the months pass. He calls it the best contact he has with things in the home state.

* * *

Four weeks to the day after his daughter, Susan, was born, **Lieutenant Russell Jackson**, medical officer of the United States Navy, arrived in Madison to visit his family. Having missed receiving the announcement of her birth, he did not know until he landed in New York that his daughter had been born.

A former member of the Jackson Clinic staff, Madison, Lieutenant Jackson has been on destroyer duty in the Pacific and the Atlantic for the last year.

* * *

A simple formula for the complete elimination of cases of shell shock is the recent development produced by **Colonel William J. Bleckwenn**, former professor of neuropsychiatry at the University of Wisconsin who is now commanding officer of the 135th Medical Regiment and chief surgeon at an advanced base somewhere in the southwest Pacific and has more than one hundred Army medical units under his control in Australia, New Guinea, and the Solomon islands. Through experience with cases on the immediate battlefront, Colonel Bleckwenn believes that three or four days of rest, with hot food, clean clothing, and sympathetic conversation, are easily able to cure the nervous exhaustion which doctors in the last war called "shell shock."

Colonel Bleckwenn insists that the prevention of shell shock, which he defines as being an emotional breakdown resulting from an accumulation of unpleasantnesses, is a forward-area problem. He has encouraged the establishment of rest camps immediately behind the lines. He believes that pulling an exhausted man thousands of miles from his combat area makes him a chronic case and that the trouble in the last war was that such emotionally strained men were taken far from the front lines. He favors sending young psychiatrists into the war areas where they will be able to handle sympathetically cases of men who are cracking and advises that "this is the only way we may be able to save America from a repetition of the 'shell shock' casualties incurred in the last war."

* * *

W. C. KEETTEL

Dr. William C. Keettel, formerly obstetric consultant with the State Board of Health, is now serving as chief of obstetrics and gynecology at the Clinton Engineer Works, Knoxville, Tennessee, in the employment of the United States War Department. He left August 13 for his new position.

Mrs. Keettel is remaining in Madison for the time being and plans to join her parents in the near future at Valentine, Nebraska.

Captain Thomas L. Gatch, master of the Yankee battleship, *Old Nameless*, is at present taking physiotherapy treatments at the navy medical center at Bethesda, Maryland. Last November 14 an entire Japanese fleet was wiped out in an epic battle in which the *Old Nameless* and the task force that she led off Savo Island in the Solomons participated.

Supervising the case is a Milwaukeean, **Lieutenant Commander John F. Wyman**, who left a position at Sacred Heart Sanitarium for service with the navy.

Scores of other men—enlisted men as well as officers—are also at the center at Bethesda, where miraculous treatment and surgery is being used in connection with cases in which wounds have affected the muscles, the nerves, or the bones. Here flesh is being remolded, faces rebuilt, shattered bones mended and straightened, and unstrung nerves quieted.

By providing immediate care, the military medical services are shortening the hospitalization and hastening the convalescence of such patients and hope to return men to active duty in greater numbers than in previous wars and to minimize the work that the veterans' administration will be called upon to do in further hospitalization, treatment, or rehabilitation.

* * *

Lieutenant Commander Randolph W. Kreul, until recently a practicing physician in Racine, is now on active duty with the medical corps of the United States Navy at the Mare Island Naval Hospital, California.

Mrs. Kreul and their two sons, Randolph, Jr., and Richard, will remain in Racine.

IMPORTANT NOTICE

The state consultant in Wisconsin for the Procurement and Assignment Service for Physicians asks that Wisconsin physicians who have applied for service with one of the branches of the armed forces and have been rejected on physical grounds forward at once two copies of the notice of rejection to the state office of the Procurement and Assignment Service, 2750 North Teutonia Avenue, Milwaukee. This is to enable that office to clarify the status of Wisconsin physicians and to avoid recertification of men as available for service who already have been rejected.

The House of Delegates will meet on three occasions during the course of the meeting. The first session will convene at 5:00 p. m., Sunday, September 12; the second at 6:45 p. m., Monday, September 13; and the final session at 8:00 a. m., Tuesday, September 14.

THE WISCONSIN MEDICAL JOURNAL

The Council on Scientific Work

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« « « EDITORIAL » » »

Medical Service and Public Relations

THOSE who have followed closely and with interest the proposals emanating from within the medical profession that nationally there be established an agency of medicine which could represent the views of that profession to the public are encouraged by the recent developments in this field.

At the Chicago session of the American Medical Association in early June, a Council on Medical Service and Public Relations was created. Its functions have been fully described in *The Journal of the American Medical Association.* Briefly, they involve the wholesome duties of informing both the profession and the public with respect to available facts, data, and medical opinions relating to timely and adequate rendition of medical care to the American people and, to this end, of cooperating with similar structures of the profession on the state level.

There can be nothing but support for the action of the House of Delegates; there can be no doubt as to its objectives; there is great credit due to those who brought this timely and important subject before the House; all are satisfied that the initial appointments to the Council embrace individuals who have the good of the public health at heart—men who see the objective and, from their close contact with their fellow men, are neither inarticulate nor insensitive to the implications of present-day problems.

The minutes of the first meeting of the Council[1] indicate that medicine is about ready to step ahead, carefully and deliberately but nonetheless effectively, to cement its public relations. It can be done. The consolidating agent in these difficult days involves more than oratory and far more than the presentation of revealing facts. It involves their interpretation to all—a demonstration of values and a carefully calculated sense of timing. It means work, and real work, and, above all, the giving of true facts and figures. It means placing the cards on the table, for in a democratic nation people still expect that opportunity to judge and not have someone judge for them. Medicine need never doubt the crossroads nor the ultimate way to the betterment of the health of the people if the people themselves have the opportunity to see and to understand. That contribution alone would justify the existence of the Council on Medical Service and Public Relations. S. E. G.

[1] Medical Service and Public Relations, J. A. M. A. 122:1022 (Aug. 7) 1943.

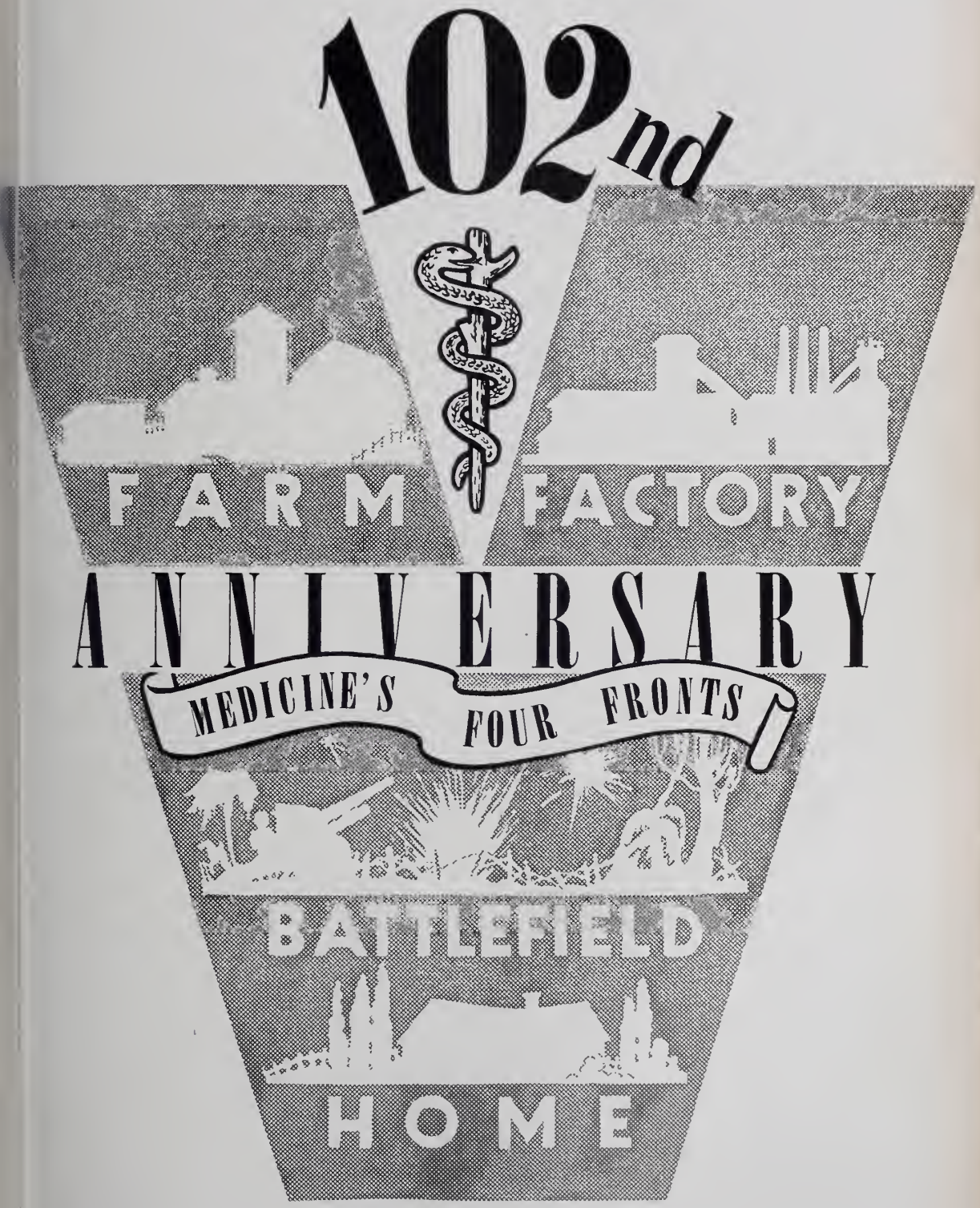
. . . . THE PRESIDENT'S PAGE . . . .

THE House of Delegates at the forthcoming Annual Meeting will be urged to consider as a major problem how the State Medical Society can best assist the Board of Public Welfare in the problem of improving facilities—physical, personnel, and treatment—for the care of those assigned to institutions on the state level. These institutions care for the medical problems of persons who are mentally ill, feeble-minded, and epileptic and are, therefore, in our domain since we have assumed responsibility for the public health of the state through tradition and performance.

At the request of the State Board of Public Welfare, an advisory committee of the State Medical Society has been appointed as an official arm of the Board. This committee will function and do an excellent job if encouraged by action and results. Much of its success will depend on collateral action by every member of the Society interesting himself in this effort.

You can best help by following reports and summaries of the problems appearing in the lay press and our *Journal.* Discuss the details at your county meetings and urge your legislators to take cognizance of the needs for rehabilitation of these institutions, for better personnel, and for diagnostic study of admittances and close follow-up of patients.

As has been disclosed by the Committee on Mental Hygiene and Institutional Care, your county institution likewise requires the scrutiny of your county society and the creation of public opinion to bring it up to the level which would be at least that of minimum standards in the light of present knowledge. By your active participation in this assignment, you will serve your state, county, and profession and render a humane service to those confined to our institutions. Wisconsin has high ideals for service; our institutions should be consistent with such ideals.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ANNIVERSARY
MEDICINE'S FOUR FRONTS
BATTLEFIELD
HOME

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PREVENTION OF
OCCUPATIONAL DISEASES

MEDICINE
AT HOME and IN WAR
anniversary
Lilly
ELI LILLY AND COMPANY
CHEMOTHERAPY
ARMY
WISCONSIN
CALCIFIED

Reservations Indicate Record Attendance At One Hundred Second Anniversary Meeting

ROUND-TABLE luncheon reservations received immediately after release of the special bulletin indicate that there will be a record attendance at the meeting in Milwaukee, September 13, 14 and 15. The number of reservations received has been a reliable barometer of attendance at the meeting.

Final study and approval of the scientific program was given at the meeting of the Council on Scientific Work on August 5. "This" declared Dr. E. R. Schmidt, the chairman of the Council on Scientific Work, "is the most effectively integrated scientific program prepared since I have been a member of the Council on Scientific Work. A program of this character is the Council's own reason for being."

E. R. SCHMIDT

House of Delegates

The initial meeting of the House of Delegates will be held on Sunday, September 12. At this meeting, members of the House, as well as secretaries and presidents of county medical societies, will hear the special reports of the president, officers, and committee chairmen.

The officers of the Society will be nominated by a special nominating committee of the House which is formed of one representative from each Councilor District elected by the delegates from the thirteen Councilor Districts. The nominating committee makes its report to the third meeting of the House which is scheduled to be held Tuesday morning at 8:00 a. m.

Councilors are nominated by a caucus of the delegates from those districts in which a councilor's term expires and are elected by vote of the House. Councilors whose terms expire at the September meeting of the Society are: W. T. Clark, Janesville, Third District; B. I. Pippin, Richland Center, Fourth District; A. H. Heidner, West Bend, Fifth District; S. E. Gavin, Fond du Lac, Sixth District, and R. W. Blumenthal, Milwaukee, Twelfth District.

Other officers to be elected include a president-elect, the speaker and vice-speaker of the House of Delegates and delegate and alternate delegate to the American Medical Association.

Secretaries' Conference

At 2:30 p. m. on Sunday, September 12, the Secretaries' Conference will be called to order. The secretaries and presidents of each of the component county medical societies, as well as the chairmen of special committees of local societies, have been invited and urged to attend. Also in attendance will be councilors and officers of the State Society.

The presiding officer will be President Russell M. Kurten. The program for the conference is as follows:

The American Medical Association—Dr. Olin West, Chicago, Secretary, American Medical Association

The New Council on Medical Service and Public Relations—Dr. A. W. Adson, Rochester

State Medical Associations and Their Relationship to Component Societies—Mr. T. A. Hendricks, Indianapolis; Secretary, Indiana State Medical Association

Motion Pictures in County Medical Society Programs—Dr. H. K. Tenney, Madison

Scientific Program

While the role of the medical profession in the war will be stressed throughout the scientific program, sight has not been lost of the importance of maintaining to a high degree the knowledge required and the new developments available for the treatment of civilian injuries and diseases. Much of the subject matter to be covered is applicable to military medicine and civilian practice alike. Particularly is this true of the symposium on

peptic ulcer, a condition which has constituted a definite military medical problem following the induction of a large number of men into the services.

The arrangement of the scientific program has been under the immediate direction and supervision of Dr. Francis D. Murphy, who was assigned the active work in its preparation. Throughout the development of the program, the entire Council on Scientific Work has, of course, aided and assisted Dr. Murphy.

Scientific Exhibits

More scientific exhibits will be shown in the main arena of the Milwaukee Auditorium than ever before in the history of the Society. Educators in all fields have recognized the outstanding value of three dimensional exhibits, and greater emphasis is being placed upon this modality of medical education than ever before.

The Council on Scientific Work appointed one of its members, Dr. C. D. Neidhold, as director of scientific exhibits. Throughout the deliberations of the Council on Scientific Work in the formation of the program, Dr. Neidhold simultaneously laid his plans for the exhibits with the result that many of the subjects that are presented from the didactic lecture platform in Plankinton Hall will also be given in the scientific section of the main arena.

One of the outstanding exhibits will be the obstetric manikin demonstrations which will be presented on the stage of the exhibit hall. Through the cooperation of the Wisconsin Society of Obstetrics and Gynecology, the Council on Scientific Work has developed an exhibit. An exhibit of similar character has been conducted at the spring clinics of the Society and has there demonstrated its popularity. The obstetric manikin demonstration scheduled to be presented at the midmorning and midafternoon recess periods will employ as demonstrators eminent instructors and teachers. Full details concerning the out-of-state guests who are scheduled to present these demonstrations are included in the descriptive material in the scientific exhibit section of the program.

Annual Dinner

Newspaper articles have called attention to the fact that the United States is not now ready to take over postwar problems, and many have urged that more effort be directed to anticipating the problems which will be presented.

"The Role of the Medical Profession in Planning for Postwar Medical Service" will be the subject presented by Dr. James E. Paullin, president of the American Medical Association.

The Surgeon General of the United States Army, Major General Norman T. Kirk, has provided the second speaker, Lieutenant Colonel Walter B. Martin, M. C., to discuss "The American Doctor at War."

Hospital Relations

Dr. J. E. Habbe, chairman of the Committee on Hospital Relations, has made final arrangements for the special section meeting on hospital relations. This section, to be presented this year for the first time, is designed to afford an opportunity for physicians and hospitals to discuss problems of mutual interest. Invitations have been extended to chiefs of staff, hospital superintendents, members of hospital boards, and others to attend the meeting. In addition to the section program which will be presented on Wednesday morning at the time that all other section programs are conducted, there will be held at noon a luncheon at which Dr. Harry W. Sargeant, Superintendent of the Milwaukee County Hospital, will preside. Scheduled to speak at this luncheon is Father Alphonse M. Schwitalla, S. J., Ph. D., dean of the St. Louis University School of Medicine.

Woman's Auxiliary

In addition to the events which have been scheduled for members of the Society, an informative program has been scheduled for physicians' wives by the Auxiliary. Attendance at Auxiliary functions is not limited to members of that organization, but all physicians' wives are cordially invited by Mrs. E. S. Schmidt, president of the Woman's Auxiliary, and Mrs. H. O. Zurheide, Convention Chairman. Bring your wife and let her enjoy the functions of the Auxiliary.

See you in Milwaukee!

Meeting High Lights

SUNDAY, SEPTEMBER 12 . . .

P. M.
2:30 Secretaries' Conference
5:00 House of Delegates—Banquet Room (Fifth Floor), Hotel Schroeder

MONDAY, SEPTEMBER 13 . . .

A. M.
7:30 Registration—Main Arena, Milwaukee Auditorium
Breakfast Round-Tables—Hotel Schroeder
8:00 Scientific Motion Pictures—Plankinton Hall, Milwaukee Auditorium
9:00 General Session—Plankinton Hall, Milwaukee Auditorium
10:00 Recess to View Exhibits
10:30 General Session—Plankinton Hall, Milwaukee Auditorium

P. M.
12:10 Round-Table Luncheons—Hotel Schroeder
2:00 General Session—Plankinton Hall, Milwaukee Auditorium
3:00 Recess to View Exhibits
3:30 General Session—Plankinton Hall, Milwaukee Auditorium
6:45 House of Delegates—Crystal Ballroom (Fifth Floor), Hotel Schroeder
8:30 Smoker—Crystal Ballroom (Fifth Floor), Hotel Schroeder

TUESDAY, SEPTEMBER 14 . . .

A. M.
8:00 House of Delegates—Banquet Room (Fifth Floor), Hotel Schroeder
Scientific Motion Pictures—Plankinton Hall, Milwaukee Auditorium
9:00 General Session—Plankinton Hall, Milwaukee Auditorium
10:00 Recess to View Exhibits
10:30 General Session—Plankinton Hall, Milwaukee Auditorium

P. M.
12:10 Round-Table Luncheons—Hotel Schroeder
2:00 General Session—Plankinton Hall, Milwaukee Auditorium
3:00 Recess to View Exhibits
3:30 General Session—Plankinton Hall, Milwaukee Auditorium
6:45 Annual Dinner—Crystal Ballroom, Hotel Schroeder

WEDNESDAY, SEPTEMBER 15 . . .

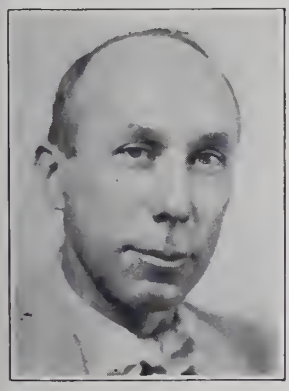
A. M.
8:00 Scientific Motion Pictures—Plankinton Hall, Milwaukee Auditorium
9:00 Section on Hospital Relations—Engelmann Hall, Milwaukee Auditorium
Section on Internal Medicine and Cardiology—Plankinton Hall, Milwaukee Auditorium
Section on Obstetrics and Gynecology—South Juneau Hall, Milwaukee Auditorium
Section on Ophthalmology—North Juneau Hall, Milwaukee Auditorium
Section on Orthopedics—Walker Hall, Milwaukee Auditorium
Section on Pediatrics—North Kilbourn Hall, Milwaukee Auditorium
Section on Radiology—Committee Room A, Milwaukee Auditorium
Section on Surgery—South Kilbourn Hall, Milwaukee Auditorium
Section on Urology—Committee Room D, Milwaukee Auditorium

P. M.
12:00 Luncheon, Section on Hospital Relations—Hotel Schroeder
12:10 Round-Table Luncheons—Hotel Schroeder
2:00 General Session—Plankinton Hall, Milwaukee Auditorium
Section on Otolaryngology—North Juneau Hall, Milwaukee Auditorium

OUR GUEST SPEAKERS

Dr. Frank C. Mann
Professor of Pathology and Experimental Physiology and Surgery, University of Minnesota Graduate School, Rochester

Dr. Cecil J. Watson
Professor of Internal Medicine, University of Minnesota Medical School, Minneapolis



Dr. Marion A. Blankenhorn
Professor of Medicine, University of Cincinnati College of Medicine, Cincinnati

Dr. Warren H. Cole
Professor of Surgery, University of Illinois College of Medicine, Chicago

SUNDAY EVENING, SEPTEMBER 12 . . .

5:00 House of Delegates
Banquet Room (Fifth Floor), Hotel Schroeder

MONDAY MORNING, SEPTEMBER 13 . . .

7:30 REGISTRATION
Milwaukee Auditorium

BREAKFAST ROUND TABLES 7:30—8:45 A. M.

Hotel Schroeder

1. Bedside Medicine and Newer Drugs
   Ovid O. Meyer, associate professor of medicine, University of Wisconsin Medical School, Madison
   Parlor A, Fourth Floor
2. Prevention and Treatment of Wound Infections
   Joseph M. King, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee
   Parlor B, Fourth Floor
3. Improvisations to Cope with Medical and Surgical Emergencies in the Home
   Justin D. Leahy, Park Falls
   Parlor C, Fourth Floor
4. Precautions in Absentee Diagnosis, Treatment and Prescribing by Telephone
   Joseph Lettenberger, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee
   Parlor D, Fourth Floor
5. Medication for Common Skin Diseases
   Maurice J. Reuter, Milwaukee
   Parlor E, Fourth Floor
6. Obstetrical Anesthesia
   Arthur A. Cantwell, Shawano
   Parlor F, Fourth Floor

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:15 Scientific Motion Pictures
Preparation of Plasma
(Sound and color)

Symposium on the Liver

9:00 Some Problems in the Physiology of the Liver
Frank C. Mann, professor of pathology and experimental physiology and surgery, University of Minnesota Graduate School, Rochester, Minnesota

9:20 Studies of Liver Disease with Correlation of Clinical Features and Liver Function Tests
Cecil J. Watson, professor of internal medicine, University of Minnesota Medical School, Minneapolis, Minnesota

9:40 Differential Diagnosis of Jaundice
Marion A. Blankenhorn, professor of medicine, University of Cincinnati College of Medicine, Cincinnati, Ohio

10:00 Recess to View Exhibits

> This time is set aside to give you an opportunity to visit the technical and scientific exhibits. Please stop in and see them.

10:30 Surgery of the Biliary Tract
Carl W. Eberbach, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee

10:50 Preoperative and Postoperative Complications and Treatment of the Jaundiced Patient
Matthew A. McGarty, La Crosse

11:10 Summary and Discussion of These Papers
Warren H. Cole, professor of surgery, University of Illinois College of Medicine, Chicago, Illinois

11:30 Recess to View Exhibits

MONDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. Liver Function Tests and Their Clinical Value
   Cecil J. Watson, Minneapolis
   Parlor A, Fourth Floor
2. Jaundice
   Marion A. Blankenhorn, Cincinnati, Ohio
   Parlor B, Fourth Floor
3. Surgical Advances from the War
   Warren H. Cole, Chicago
   Parlor C, Fourth Floor
4. Pathologic Aspects of Undernutrition
   Paul R. Cannon, Professor of Pathology, University of Chicago, The School of Medicine, Chicago
   Parlor D, Fourth Floor
5. The Relation of Peptic Ulcer to Cancer of the Stomach
   George B. Eusterman, professor of medicine, University of Minnesota Graduate School, Minneapolis
   Parlor E, Fourth Floor
6. Some Problems in the Physiology of the Liver
   Frank C. Mann, Rochester, Minnesota
   Parlor F, Fourth Floor
7. When Is Peptic Ulcer a Medical and When Is It a Surgical Problem?
   Donald C. Balfour, professor of surgery, University of Minnesota Graduate School, Rochester, Minnesota
   Parlor G, Fourth Floor
8. Jaundice and Its Surgical Aspects
   Matthew A. McGarty, La Crosse
   Parlor H, Fourth Floor
9. Breast Surgery
   Frederick A. Stratton, clinical professor of surgery, Marquette University School of Medicine, Milwaukee
   Parlor I, Fourth Floor
10. Colitis
    Joseph Shaiken, Milwaukee
    Room 607

11. Acute Appendicitis: Treatment
    Erwin R. Schmidt, professor of surgery, University of Wisconsin Medical School, Madison
    Room 619
12. Treatment of Eye Conditions Encountered by the General Practitioner
    Ferdinand H. Haessler, Milwaukee
    Room 707
13. Ear Conditions in General Practice
    William E. Grove, clinical professor of otolaryngology, Marquette University School of Medicine, Milwaukee
    Room F, Fifth Floor
14. What Drugs to Use in the Treatment of Diseases of the Heart
    Chester M. Kurtz, Milwaukee, associate professor of clinical medicine, University of Wisconsin Medical School, Madison
    Pine Room, Fifth Floor
15. New Conceptions in the Administration of Immunization for Whooping Cough and Other Contagious Disease Serums and Vaccines
    William D. Stovall, professor of hygiene, University of Wisconsin Medical School, Madison
    Pere Marquette Room, Fifth Floor
16. Radiologic Problem Clinic for the General Practitioner
    S. Archibald Morton, clinical professor of radiology, Marquette University School of Medicine, Milwaukee
    Committee Room, Fifth Floor
17. Obstetrics in the Home
    Woodruff Smith, Ladysmith
    Room B, Fifth Floor
18. Pediatric Practice in the Office and Home
    Abraham B. Schwartz, assistant clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee
    Room C, Fifth Floor
19. Chemotherapy in the Urinary Tract Diseases
    Hartwick M. Stang, Eau Claire
    Room D, Fifth Floor
20. Influence of Surgery on Tuberculosis
    Anthony V. Cadden, Muirdale Sanatorium, Wauwatosa
    Room E, Fifth Floor

MONDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

Symposium on Peptic Ulcer

2:00 Etiology, Pathology and Incidence of Peptic Ulcer
Frederick A. Stratton, Milwaukee

2:20 Bleeding Peptic Ulcer
2:20 Medical Treatment
Joseph Shaiken, Milwaukee
2:40 Surgical Treatment
Russell M. Kurten, Racine, president, The State Medical Society of Wisconsin

3:00 Recess to View Exhibits

> Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

3:30 Preparation of Physicians for the Armed Services
Rear Admiral Ross T. McIntire, Surgeon General of the United States Navy, Washington, D. C.

4:00 Observations on Gastric Carcinoma in Its Earliest Stages
George B. Eusterman, Rochester, Minnesota

4:20 Operation of Choice in Peptic Ulcer
Erwin R. Schmidt, professor of surgery, University of Wisconsin Medical School, Madison

4:40 Discussion and Summary of Symposium
Donald C. Balfour, Rochester, Minnesota

Scientific Motion Pictures

MONDAY EVENING . . .

6:45 House of Delegates
Crystal Ballroom (Fifth Floor), Hotel Schroeder

8:30 Smoker
Refreshments; Entertainment, Blatz Brewing Company Quartet, and other features.

OUR GUEST SPEAKERS

Rear Admiral Ross T. McIntire

Surgeon General of the United States Navy, Washington, D. C.

Dr. George B. Eusterman

Professor of Medicine, University of Minnesota Graduate School, Minneapolis

Dr. Donald C. Balfour

Professor of Surgery, University of Minnesota Graduate School, Rochester

Dr. John Romano

Professor of Psychiatry, University of Cincinnati College of Medicine, Cincinnati

TUESDAY MORNING, SEPTEMBER 14 . . .

8:00 House of Delegates
Banquet Room (Fifth Floor), Hotel Schroeder

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:15 Scientific Motion Pictures
The Right to Hear
(Sound and color)

9:00 Problems in Plastic Surgery of the Face
C. R. Dix, instructor in maxillo-facial surgery, Marquette University School of medicine, Milwaukee

9:20 The Place of Sulfonamides in Surgery
Arnold S. Jackson, Madison

9:40 Psychiatric Problems Arising from Military Service
John Romano, professor of psychiatry, University of Cincinnati College of Medicine, Cincinnati, Ohio

10:00 Recess to View Exhibits

The technical exhibits make it possible to present the annual meeting without a registration fee. Express your appreciation to the exhibitors by visiting their booths.

10:30 Virus Diseases of Man
Edward R. Krumbiegel, assistant clinical professor of public health, Marquette University School of Medicine, Milwaukee

10:50 Reports of Officers

11:10 Address of President

TUESDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. Medical Problems Confronting Asylum Physicians and Superintendents
   Henry H. Christofferson, Colby, chairman, Committee on Mental Hygiene and Institutional Care
   Parlor A, Fourth Floor
2. Psychiatric Examination in General Practice
   Saul K. Pollack, Milwaukee
   Parlor B, Fourth Floor
3. Transfusions and Fluid Balance
   Frederick A. Coller, professor of surgery, University of Michigan Medical School, Ann Arbor, Michigan
   Parlor C, Fourth Floor
4. Treatment of Patients Suffering from Wounds due to Poison Gas
   Raymond F. Wagner, Oshkosh
   Anthony R. Curreri, assistant professor of surgery, University of Wisconsin Medical School, Madison
   Elston L. Belknap, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee
   Parlor D, Fourth Floor
5. Sulfonamides in Surgical Practice
   Arnold S. Jackson, Madison
   Parlor E, Fourth Floor
6. Diagnosis and Treatment of Cancer of the Bowel
   Claude F. Dixon, associate professor of surgery, University of Minnesota Graduate School, Rochester, Minnesota
   Parlor F, Fourth Floor
7. Diseases of Viral Etiology
   Edward R. Krumbiegel, Milwaukee
   Rear of Banquet Room, Fifth Floor
8. Anemias and Leukemias
   Frederick W. Madison, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee
   Parlor H, Fourth Floor
9. Emotional Disorders in Selective Service
   Major John A. Grab, M. C., United States Selective Service, Madison
   Parlor I, Fourth Floor
10. Virus Pneumonia: Diagnosis and Complications
    Alvin G. Koehler, Oshkosh
    Room 607
12. Urinary Tract Diseases
    Robert S. Irwin, Milwaukee
    Room 707
13. Toxic Reactions of Dinitrotoluene
    Howard L. Reed, medical director, Badger Ordnance Works, Baraboo
    Pine Room
14. Poliomyelitis: Immediate and Remote Results
    Eben J. Carey, dean and professor of anatomy, Marquette University School of Medicine, Milwaukee
    Committee Room, Fifth Floor
15. Irradiation Treatment of Carcinoma (External)
    Harry R. Foerster, assistant professor of dermatology, University of Wisconsin Medical School, Madison, and assistant clinical professor of dermatology, Marquette University School of Medicine, Milwaukee
    Pere Marquette Room, Fifth Floor
16. Psychosomatic Medicine
    John Romano, professor of psychiatry, University of Cincinnati College of Medicine, Cincinnati, Ohio
    Room B, Fifth Floor
17. Medical Problems Created by Employment of Women in Industry
    Paul A. Brehm, director, Industrial Hygiene Unit, State Board of Health, Madison
    Herbert G. Brehm, Racine
    Mr. G. F. Nuernberger, supervisor, Health and Safety Division, Industrial Relations Department, Allis Chalmers, Milwaukee
    Room C, Fifth Floor

18. Fracture Problems
    Robert P. Montgomery, Milwaukee
    Room D, Fifth Floor

19. Local Anesthesia in Sprains and Strains
    Chester C. Schneider, Milwaukee
    Room E, Fifth Floor

20. Induction of Labor
    George W. Walter, Racine
    Arthur A. Cantwell, Shawano
    Room F, Fifth Floor

21. Past-Presidents' Luncheon
    Gunnar Gundersen, La Crosse
    Parlor G, Fourth Floor

TUESDAY AFTERNOON . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

2:00 Uses of Blood Substitutes in Hemorrhage, Shock and Protein Deficiencies
Frederick A. Coller, professor of surgery, University of Michigan Medical School, Ann Arbor, Michigan

2:20 Immediate and Remote Complications of Sulfonamide Therapy
John C. Grill, associate professor of pathology and bacteriology, Marquette University School of Medicine, Milwaukee

2:40 Medical Aspects of Chemical Warfare
L. H. Gaston, assistant regional medical officer, Sixth Civilian Defense Region, Chicago

3:00 **Recess to View Exhibits**

On the stage in the exhibit hall, Dr. M. E. Davis, Associate Professor of Obstetrics and Gynecology, University of Chicago School of Medicine, will conduct an obstetric manikin demonstration on the following subject: "A Discussion of the Management of Breech Presentation with a Demonstration of the Various Methods of Delivery; Also "A Discussion of Version and Extraction."

3:30 Present Status of Hemorrhagic Diseases
Frederick W. Madison, Milwaukee

3:50 Cancer of the Bowel: Surgical Treatment
Claude F. Dixon, associate professor of surgery, University of Minnesota Graduate School, Rochester, Minnesota

4:10 A Contrast of Selective Service and United States Army Physical Examinations
Major John A. Grab, M. C., United States Selective Service, Madison

4:30 Scientific Motion Pictures
Subject to be Announced

6:45 ANNUAL DINNER
Hotel Schroeder, Crystal Ballroom

WEDNESDAY MORNING, SEPTEMBER 15 . . .

GENERAL SESSION . . .

Plankinton Hall, Milwaukee Auditorium

8:30 Scientific Motion Pictures
Plastic Surgery
(Sound and color)

SECTION ON HOSPITAL RELATIONS . . .

Engelmann Hall, Milwaukee Auditorium, Second Floor

Chairman: J. E. Habbe, Milwaukee

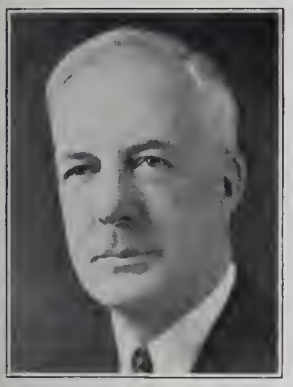
9:00 Professional Accounting
Harold M. Coon, professor of hospital administration, University of Wisconsin Medical School, Madison

Dr. William A. O'Brien

Professor of Preventive Medicine and Public Health, University of Minnesota Medical School, Minneapolis

Mr. J. W. Holloway, Jr.

Director, Bureau of Legal Medicine and Legislation, American Medical Association, Chicago



Dr. William A. Coventry

Duluth, Minnesota

Father Alphonse M. Schwitalla, S. J., Ph. D.

Dean, St. Louis University School of Medicine, St. Louis

9:20 Problems Concerning Graduate Education and Employment of Nurses, Interns and Residents
William A. O'Brien, professor of preventive medicine and public health, University of Minnesota Medical School, Minneapolis

9:40 Hospitals in the Selection of Medical Staffs
Mr. J. W. Holloway, Jr., director, Bureau of Legal Medicine and Legislation, American Medical Association, Chicago

10:00 Recess to View Exhibits

Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

10:30 Interhospital Relations
William A. Coventry, Duluth, Minnesota

10:50 The Hospital Library
Gorton Ritchie, associate professor of pathology, University of Wisconsin Medical School, Madison

11:10 Practical Experience with the Trained Attendants
Katharine Shepard, R. N., Superintendent of Household Nursing Association, Boston

11:30 Recess to View Exhibits

NOON LUNCHEON

Hotel Schroeder, Banquet Room, Fifth Floor

12:00 Administrative and Professional Problems of Medical Practice in the Hospital
Father Alphonse M. Schwitalla, S. J., Ph. D., dean, St. Louis University School of Medicine, St. Louis, Missouri

TELEPHONE SERVICE AT AUDITORIUM

Your telephone number at the Milwaukee Auditorium will be Broadway 8030. When you leave to attend sessions of the One Hundred Second Anniversary Meeting, leave word at your home and office that you can be reached at that number.

SECTION ON INTERNAL MEDICINE AND CARDIOLOGY . . .

Dr. Chauncey C. Maher

Associate Professor of Medicine, Northwestern University Medical School, Chicago

Dr. Paul S. Rhoads

Associate Professor of Medicine, Northwestern University Medical School, Chicago

Plankinton Hall, Milwaukee Auditorium, Second Floor

Chairman: Alvin G. Koehler, Oshkosh

9:00 Neurologic Conditions of Interest to the General Practitioner
John L. Garvey, clinical professor of neurology, Marquette University School of Medicine, Milwaukee

9:20 Chronic Diseases of the Lung Mistaken for Tuberculosis
Anthony V. Cadden, Muirdale Sanatorium, Wauwatosa

9:40 Recognition of Early Myocardial Failure
Chauncey C. Maher, associate professor of medicine, Northwestern University Medical School, Chicago, Illinois

10:00 **Recess to View Exhibits**

> Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

10:30 Rheumatic Fever: Diagnosis and Treatment
Paul S. Rhoads, associate professor of medicine, Northwestern University Medical School, Chicago

Major C. S. Higley

Chief of Medical Service, Truax Field, Madison

10:50 Treatment of the Various Pneumonias
Major C. S. Higley, Truax Field, Madison

11:10 Recent Advances in Diabetes Mellitus
Elwood W. Mason, clinical instructor in medicine, Marquette University School of Medicine, Milwaukee

11:30 **Recess to View Exhibits**

SECTION ON OBSTETRICS AND GYNECOLOGY . . .

South Juneau Hall, Milwaukee Auditorium, First Floor

Chairman: Robert L. Cowles, Green Bay

9:00 Terminal Caudal Anesthesia
Hugh A. Cunningham, assistant clinical professor of anesthesia, Marquette University School of Medicine, Milwaukee

9:20 Discussant:
John W. Harris, professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison

9:30 Diagnosis of Carcinoma of the Uterus
Ralph E. Campbell, associate professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison

9:50 Discussant:

Albert H. Lahmann, associate clinical professor of obstetrics and gynecology, Marquette University School of Medicine, Milwaukee

10:00 Recess to View Exhibits

> Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

10:30 Diabetes in Pregnancy

George S. Kilkenny, instructor in obstetrics and gynecology, Marquette University School of Medicine, Milwaukee

10:50 Discussant:

Elmer L. Sevringhaus, professor of medicine, University of Wisconsin Medical School, Madison

Dr. Ralph A. Reis

Assistant Professor of Obstetrics and Gynecology, Northwestern University Medical School, Chicago

11:00 Sterility

Ralph A. Reis, assistant professor of obstetrics and gynecology, Northwestern University Medical School, Chicago

11:20 Discussant:

Carl S. Harper, assistant clinical professor of obstetrics and gynecology, University of Wisconsin Medical School, Madison

11:30 Recess to View Exhibits

SECTION ON OPHTHALMOLOGY . . .

Dr. Sanford R. Gifford

Professor of Ophthalmology, Northwestern University Medical School, Chicago

North Juneau Hall, Milwaukee Auditorium, First Floor

Chairman: William E. Grove, clinical professor of otolaryngology, Marquette University School of Medicine, Milwaukee

9:00 The Eye in General Diagnosis

Sanford R. Gifford, professor of ophthalmology, Northwestern University Medical School, Chicago

9:20 Vision in Anisometropia

Lyman A. Copps, Marshfield Clinic, Marshfield

9:40 Discussant:

Jasper M. Molsberry, Milwaukee

10:00 Recess to View Exhibits

> Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

10:30 Complications in Cataract Surgery

Raymond C. Warner, Milwaukee

10:50 Discussion

Frederick A. Davis, professor of ophthalmology, University of Wisconsin Medical School, Madison

11:00 Evaluation of Blood Studies in Postoperative Bleeding after Cataract Surgery

Eugene E. Neff, associate professor of ophthalmology, University of Wisconsin Medical School, Madison

11:20 Discussion

F. Herbert Haessler, Milwaukee

11:30 Recess to View Exhibits

SECTION ON ORTHOPEDICS . . .

Walker Hall, Milwaukee Auditorium, First Floor

Chairman: Robert E. Burns, professor of orthopedic surgery, University of Wisconsin Medical School, Madison

9:00 Posture in School Children
David J. Ansfield, Milwaukee

9:15 Discussant:
Robert P. Montgomery, Milwaukee

9:20 The Value of Early Recognition of Congenital Dislocation of the Hip
Vernon C. Turner, Evanston, Illinois

9:35 Discussant:
Herman C. Schumm, Milwaukee

9:40 Sequelae of Fractured Hips and Their Treatment
Chester C. Schneider, Milwaukee

9:55 Discussant:
R. E. Burns, Madison

10:00 Recess to View Exhibits

> Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

10:30 Treatment of Compound Fractures
Edward L. Compere, associate professor of orthopedics, University of Illinois College of Medicine, Chicago

10:50 Discussant:
Albert C. Schmidt, Milwaukee

11:00 Low Back Injuries and Compensation Cases
W. E. Wolcott, Green Bay

11:20 Discussant:
Walter P. Blount, Milwaukee

11:30 Recess to View Exhibits

SECTION ON PEDIATRICS . . .

Dr. Hart E. Van Riper
Assistant Director for Maternal and Child Health, Division of Health Services, Washington, D. C.

Dr. Paul H. Holinger
Assistant Professor of Laryngology, University of Illinois College of Medicine, Chicago

North Kilbourn Hall, Milwaukee Auditorium, First Floor

Chairman: Henry A. Sincock, Superior

9:00 Better Health for Children: Physicians and the Social Security Program
Hart E. Van Riper, assistant director for maternal and child health, Division of Health Services, Washington, D. C.

9:20 Reducing the Hazards of the First Week of Life
John W. Prentice, Ashland
Discussant:
Samuel E. Kohn, Milwaukee

9:40 The Infant Larynx
Paul H. Holinger, assistant professor of laryngology, University of Illinois College of Medicine, Chicago

10:00 Recess to View Exhibits

Dr. Edgar J. Huenekens
Clinical Professor of Pediatrics, University of Minnesota Graduate School and University of Minnesota Medical School, Minneapolis

> Take this time to visit the technical and scientific exhibits in the main arena. The exhibitors will appreciate seeing you.

10:30 Immunization in Pediatric Practice
Edgar J. Huenekens, clinical professor of pediatrics, University of Minnesota Medical School and University of Minnesota Graduate School, Minneapolis; member of the Immunization Committee of the American Academy of Pediatrics
10:50 Discussant:
S. F. Morgan, assistant clinical professor of pediatrics, Marquette University School of Medicine, Milwaukee

11:00 Malocclusion and Malformations of the Jaws and Face in Children Necessitating Early Orthodontic and Surgical Care
Matthew N. Federspiel, associate clinical professor of surgery, Marquette University School of Medicine, Milwaukee
11:20 Discussion
Dr. Russell A. Hering, Milwaukee

11:30 Recess to View Exhibits

SECTION ON RADIOLOGY . . .

Committee Room A, Milwaukee Auditorium, Second Floor

Chairman: Lester W. Paul, Madison
9:00 Business Meeting of Section
9:30 Experiences with Priodax, a New Dye for Gallbladder Visualization
Hans W. Hefke, Milwaukee
9:50 Discussion

10:00 Recess to View Exhibits

10:30 Round-Table Discussion with Case Reports
William T. Clark, Janesville
Theodore Sokow, Kenosha
S. Archibald Morton, Milwaukee
Ernst A. Pohle, Madison
Ivan G. Ellis, Madison
Lester W. Paul, Madison

11:30 Recess to View Exhibits

SECTION ON SURGERY . . .

Lieut. Commander
Leo M. Zimmerman,
U. S. N. R.,
U. S. Naval Hospital,
Seattle, Washington

Dr. Frank McDowell
Assistant Professor
of Clinical Surgery,
Washington University
School of Medicine,
St. Louis

South Kilbourn Hall, Milwaukee Auditorium, First Floor

Chairman: Dexter H. Witte, Milwaukee
9:00 Infections and Surgery of the Hand
Thomas J. Snodgrass, Janesville
9:20 Discussion
Thomas S. O'Malley, Milwaukee, plant surgeon, A. O. Smith Corporation
9:30 Improved Surgical Treatments of Hernias
Lieutenant Commander Leo M. Zimmerman, U. S. N. R., U. S. Naval Hospital, Seattle, Washington
9:50 Discussion
Irwin Schulz, Milwaukee

10:00 Recess to View Exhibits
10:30 Skin Grafting of Burns
Frank McDowell, assistant professor of clinical surgery, Washington University School of Medicine, St. Louis
10:50 Discussion
Volney B. Hyslop, professor of oral and plastic surgery, University of Wisconsin Medical School, Madison
11:00 Intravenous Use of Amino Acids
Anthony R. Curreri, assistant professor of surgery, University of Wisconsin Medical School, Madison
11:20 Discussion

SECTION ON UROLOGY . . .

Dr. John L. Emmett
Rochester, Minnesota

Committee Room D, Milwaukee Auditorium

Chairman: Walter M. Kearns, Milwaukee

9:00 Then and Now—Twenty-five Years of Urology in a Small Clinic
Hartwick M. Stang, Eau Claire

9:20 Management of Ureteral Stone
Alexander D. Spooner, Milwaukee

9:40 Upper Urinary Tract Problems in Infants and Children
N. Warren Bourne, Milwaukee

10:00 Recess to View Exhibits

> Don't fail to see the fine display of technical and scientific exhibits in the main arena.

10:30 Discussion of Urinary Tract Injuries
Robert S. Irwin, associate professor of urology, Marquette University School of Medicine, Milwaukee

10:50 Historic Background of Litholapaxy
John L. Emmett, Rochester, Minnesota

11:10 Treatment of Resistant Infections in the Urinary Tract
Charles D. Creevy, assistant dean and professor of surgery and urology, University of Minnesota Medical School, Minneapolis

11:30 Discussion

WEDNESDAY NOON . . .

ROUND—TABLE LUNCHEONS 12:10—1:45 P. M.

Hotel Schroeder

1. The Problem of Tuberculosis
   Oscar Lotz, W. A. T. A., Milwaukee
   Parlor A, Fourth Floor
2. Treatment of Heart Failure
   Chauncey C. Maher, associate professor of medicine, Northwestern University Medical School, Chicago
   Parlor B, Fourth Floor
3. Prophylaxis of Rheumatic Fever
   Paul S. Rhoads, assistant professor of medicine, Northwestern University Medical School, Chicago
   Parlor C, Fourth Floor
4. Skin Manifestations of Systemic Diseases
   John W. Smith, Milwaukee
   Parlor D, Fourth Floor
5. Lung Diseases Simulating Pneumonia
   Major C. S. Higley, Chief of Medical Service, Truax Field, Madison
   Parlor E, Fourth Floor
6. Paralytic Squint
   Sanford R. Gifford, professor of ophthalmology, Northwestern University Medical School, Chicago
   Parlor F, Fourth Floor

7. Acute Upper Respiratory Infections and Their Control
   Dean M. Lierle, professor of otolaryngology, State University of Iowa College of Medicine, Iowa City, Iowa
   Parlor G, Fourth Floor
8. Hernias and the Wisconsin Compensation Act
   Gunnar Gundersen, La Crosse, chairman, Committee on Industrial Health
   Mr. Harry A. Nelson, director, Workmen's Compensation Division, Wisconsin Industrial Commission, Madison
   Parlor H, Fourth Floor
9. Treatment of Urinary Stones
   John L. Emmett, Rochester, Minnesota
   Parlor I, Fourth Floor
10. Urinary Diagnosis
    Charles D. Creevy, Minneapolis
    Room 607
11. Environment and Child Health in the City
    Hart E. Van Riper, assistant director for Maternal and Child Health, Division of Health Services, Washington, D. C.
    Room 619
12. Laryngeal Disease in Infancy
    Paul H. Holinger, assistant professor of laryngology, University of Illinois College of Medicine, Chicago
    Room 707
13. The Prevention of Disease in Children
    Edgar J. Huenekens, clinical professor of pediatrics, University of Minnesota Medical School, Minneapolis; member of the Immunization Committee for the American Academy of Pediatrics
    Pine Room, Fifth Floor
14. Treatment of Sterility
    Ralph A. Reis, Chicago
    Committee Room, Fifth Floor
15. Diagnosis and Localization of Brain Tumors by Roentgen Methods
    Lester W. Paul, associate professor of radiology, University of Wisconsin Medical School, Madison, and Theodore C. Erickson, associate professor of surgery, University of Wisconsin Medical School, Madison
    Pere Marquette Room, Fifth Floor
16. Rheumatic Heart Disease
    Vincent W. Koch, Janesville
    Room B, Fifth Floor
17. The Use of Intravenous Amino Acids in General Hospital Practice
    Anthony R. Curreri, assistant professor of surgery, University of Wisconsin Medical School, Madison
    Room C, Fifth Floor
18. Tropical Diseases
    Marcos Fernan-Nunez, professor of pathology and bacteriology and associate professor of public health, Marquette University School of Medicine, Milwaukee
    Room D, Fifth Floor
19. Fractures That May Be Missed
    John B. MacLaren, Appleton
    Room E, Fifth Floor
20. Abdominal Diagnosis in General Practice
    Lawrence D. Quigley, Green Bay
    Room F, Fifth Floor

WEDNESDAY AFTERNOON . . .

GENERAL SESSION . . .

Captain William E. Eaton, M. C., U. S. N.

Medical Officer in Command, U. S. Naval Hospital, Great Lakes, Illinois

Plankinton Hall, Milwaukee Auditorium

2:00 Tropical Medicine Here and in the Tropics
Marcos Fernan-Nunez, Milwaukee

2:30 Ulcer Problems in the Armed Forces
Captain William E. Eaton, M. C., U. S. N., Medical Officer in Command, U. S. Naval Hospital, Great Lakes, Illinois

3:00 Medical Education and the Armed Forces
Eben J. Carey, dean and professor of anatomy, Marquette University School of Medicine, Milwaukee

3:30 The Fate of the Practice of Medicine after the War
Alphonse M. Schwitalla, S. J., Ph. D., dean, St. Louis University School of Medicine, St. Louis, Missouri

SECTION ON OTOLARYNGOLOGY . . .

Dr. Dean M. Lierle

Professor of Otolaryngology, State University of Iowa College of Medicine, Iowa City

North Juneau Hall, Milwaukee Auditorium, First Floor

Chairman: William E. Grove, Milwaukee

2:00 Conservation of Hearing
Dean M. Lierle, professor of otolaryngology, State University of Iowa College of Medicine, Iowa City, Iowa

2:20 Vertigo and Its Treatment
Thomas L. Tolan, Milwaukee

2:40 Discussion
Thomas F. McCormick, assistant clinical professor of otolaryngology, Marquette University School of Medicine, Milwaukee

2:45 Fundamental Principles in the Diagnosis and Treatment of Respiratory Allergy
John A. Hurlbut, Madison

3:05 Discussion
William J. Frawley, Appleton

3:10 The Management of the Chronic Draining Middle Ear
Fred W. Kundert, Monroe

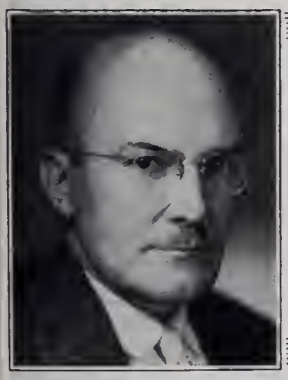
3:30 Discussion
William G. Meier, Sheboygan

Members—1943 House of Delegates

Society	*Delegate*	*Alternate Delegate*
Ashland–Bayfield–Iron	R. O. Grigsby, Ashland	J. W. Prentice, Ashland
Barron–Washburn–Sawyer–Burnett	D. L. Dawson, Rice Lake	S. O. Lund, Cumberland
Brown–Kewaunee–Door	P. R. Minahan, Green Bay	E. S. McNevins, Green Bay
	O. A. Stiennon, Green Bay	W. E. Leaper, Green Bay
Calumet	A. C. Engel, New Holstein	P. J. Mollersheim, Forest Junction
Chippewa	A. J. Somers, Chippewa Falls	Frank Sazama, Chippewa Falls
Clark	H. H. Christofferson, Colby	Not Reported
Columbia–Marquette–Adams	L. V. McNamara, Montello	E. F. Tierney, Portage
Crawford	E. M. Dessloch, Prairie du Chien	G. R. Hammes, Seneca
Dane	C. O. Vingom, Madison	J. E. Gonce, Jr., Madison
	A. R. Tormey, Madison	W. H. Marsden, Madison
	H. E. Marsh, Madison	L. R. Cole, Madison
	Louis Fauerbach, Madison	N. A. Hill, Madison
Dodge	W. E. Bargholtz, Reeseville	F. G. Bachhuber, Mayville
Douglas	J. W. McGill, Superior	H. J. Orchard, Superior
Eau Claire–Dunn–Pepin	W. R. Manz, Eau Claire	B. F. Johnson, Mondovi
Fond du Lac	D. J. Twohig, Sr., Fond du Lac	D. N. Walters, Fond du Lac
Forest	G. E. Carroll, Laona	H. C. Marsh, Crandon
Grant	J. H. Fowler, Lancaster	E. H. Spiegelberg, Boscobel
Green	J. A. Schindler, Monroe	L. E. Creasy, Monroe
Green Lake–Waushara	J. A. Kelly, Green Lake	H. C. Koch, Berlin
Iowa	S. B. Marshall, Hollandale	H. M. Walker, Dodgeville
Jefferson	G. E. Eck, Lake Mills	O. F. Dierker, Watertown
Juneau	C. A. Vogel, Elroy	A. R. Kaufman, Mauston
Kenosha	W. C. Stewart, Kenosha	L. T. Kent, Kenosha
La Crosse	F. A. Douglas, La Crosse	Jens Rosholt, La Crosse
Lafayette	Not Reported	Not Reported
Langlade	C. E. Zellmer, Antigo	W. P. Curran, Antigo
Lincoln	R. G. Baker, Tomahawk	K. A. Morris, Merrill
Manitowoc	E. C. Cary, Reedsville	T. H. Rees, Manitowoc
Marathon	J. F. Smith, Wausau	E. E. Flemming, Wausau
Marinette–Florence	A. T. Nadeau, Marinette	H. W. Haasl, Peshtigo
Milwaukee	C. R. Marquardt, Milwaukee	M. C. Borman, Milwaukee
	Charles Fidler, Milwaukee	B. P. Churchill, Milwaukee
	Irwin Schulz, Milwaukee	M. W. Sherwood, Milwaukee
	W. M. Kearns, Milwaukee	J. E. Mulsow, Milwaukee
	C. M. Echols, Milwaukee	C. F. Conroy, Milwaukee
	W. A. Ryan, Milwaukee	T. F. McCormick, Milwaukee
	Norbert Enzer, Milwaukee	C. C. Schneider, Milwaukee

Society	Delegate	Alternate Delegate
	R. F. Purtell, Milwaukee	Benjamin Lieberman, Milwaukee
	R. E. Galasinski, Milwaukee	W. L. MacKedon, Milwaukee
	L. J. Van Hecke, Milwaukee	S. M. Morton, Milwaukee
	E. J. Carey, Milwaukee	M. J. Fox, Milwaukee
	S. M. Markson, Milwaukee	Edgar Habeck, Milwaukee
	J. C. Griffith, Milwaukee	Mark Bach, Milwaukee
	J. J. Pink, Milwaukee	J. M. Fons, Milwaukee
	L. W. Hipke, Milwaukee	T. J. Aylward, Milwaukee
	H. J. Gramling, Milwaukee	Aaron Yaffee, Milwaukee
	G. S. Flaherty, Milwaukee	O. A. Sander, Milwaukee
Monroe	C. S. Phalen, Sparta	L. G. Scheurich, Tomah
Oconto	A. F. Slaney, Oconto	C. R. Kwapy, Oconto
Oneida–Vilas	W. S. Bump, Rhinelander	I. E. Schiek, Rhinelander
Outagamie	G. W. Carlson, Appleton	D. W. Curtin, Little Chute
Pierce–St. Croix	C. E. McJilton, River Falls	O. H. Epley, New Richmond
Polk	L. O. Simenstad, Osceola	K. F. Johnson, Frederic
Portage	A. G. Dunn, Stevens Point	E. Wisiol, Stevens Point
Price–Taylor	J. D. Leahy, Park Falls	L. E. Nystrum, Medford
Racine	T. C. Hemmingsen, Racine	E. J. Schneller, Racine
Richland	George Parke, Sr., Viola	G. H. Benson, Richland Center
Rock	H. E. Kasten, Beloit	W. A. Munn, Janesville
Rusk	L. M. Lundmark, Ladysmith	Woodruff Smith, Ladysmith
Sauk	A. C. Edwards, Baraboo	F. R. Winslow, Baraboo
Shawano	A. A. Cantwell, Shawano	O. F. Partridge, Mattoon
Sheboygan	C. J. Weber, Sheboygan	A. C. Radloff, Plymouth
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Whitehall	Robert Krohn, Black River Falls
Vernon	W. M. Trowbridge, Viroqua	J. J. Rouse, Hillsboro
Walworth	E. D. Sorenson, Elkhorn	D. H. Jeffers, Lake Geneva
Washington–Ozaukee	Arnold Barr, Port Washington	J. G. Hoffmann, Hartford
Waukesha	R. E. Davies, Waukesha	H. T. Barnes, Delafield
Waupaca	A. M. Christofferson, Waupaca	J. H. Murphy, Clintonville
Winnebago	A. G. Koehler, Oshkosh	J. P. Canavan, Neenah
Wood	K. H. Doege, Marshfield	F. X. Pomainville, Wisconsin Rapids
Section on Cardiology	Albert Bryan, Madison	Francis Murphy, Milwaukee
Section on Ophthalmology and Otolaryngology	J. K. Trumbo, Wausau	A. H. Pember, Janesville
Section on Orthopedics	R. P. Montgomery, Milwaukee	L. D. Smith, Milwaukee
Section on Radiology	J. E. Habbe, Milwaukee	L. V. Littig, Madison

SCIENTIFIC EXHIBITS



Dr. Carl D. Neidhold of Appleton is the member of the Council on Scientific Work who was chosen this year to direct the scientific exhibits for the Annual Meeting

Applied Anatomy

Walter Zeit, Ph. D., assistant professor of anatomy, Marquette University School of Medicine, Milwaukee; and A. R. Curreri, assistant professor of surgery, University of Wisconsin Medical School; and Otto A. Mortensen, associate professor of anatomy, University of Wisconsin Medical School, Madison

The exhibit will present an anatomic dissection of the anterior abdominal wall with special reference to incisions for the approach of gall bladder, stomach, duodenum, appendix and hernial repair. The exhibit will stress what an ideal incision should offer the surgeon and patient alike. The ideal incision for the surgeon is one that will give excellent exposure of the operative field involved and which can be approached readily without too much bleeding. The patient, on the other hand, desires an abdominal wound which on healing will approach normal and which is not subject to hernias. The exhibitors will demonstrate why some incisions are ideal for the surgeon and not for the patient, and why others are ideal for the patient but not the

surgeon. An attempt will be made to demonstrate incisions that will give the surgeon optimum exposure and at the same time give the best possible wound to the patient.

Tropical Diseases

M. Fernan-Nunez, professor of pathology and bacteriology and associate professor of public health, Marquette University School of Medicine, Milwaukee

This is an exhibit emphasizing the dissemination of exotic diseases throughout the United States by increased travel and modern means of rapid transportation, especially by service men returning from war in tropical regions. The exhibit displays specimens of various parasites, eggs of helminths, insect vectors, specimens of pathologic anatomy of parasitic diseases and microphotographic transparencies of microscopic preparations. Motion pictures of parasites and patients affected with various tropical diseases will be shown.

Treatment of Fractures of Forearm, Hip, Os Calcis and Ankle Joint

J. O. Dieterle, Milwaukee

I—Single or double forearm fractures in the middle one third are often hard to reduce by closed methods. In this exhibit the technic of the open reduction method of Hey-Groves, utilizing beef bone intramedullary pegs, will be illustrated. The operation is not difficult and affords a method of getting accurate reduction of the fragments. As a rule, it is not used in children, although in certain instances it may be necessary.

II—Fracture dislocations of the ankle joint involving the lower tibial articulation should be accurately reduced and maintained by combined internal and external fixation. In certain cases the dislocated foot cannot be held reduced by simple application of a plaster cast. The exhibit will show the author's method of maintaining reduction by the use of transfixing wires.

III—In this exhibit the method of maintaining reduction in intracapsular fractures of the hip by the use of Telson screws will be illustrated. The screws are introduced subcutaneously and without the use of any special apparatus. The procedure here shown is not anything new but is presented as one of the less complicated methods of treatment of hip fractures.

IV—In the exhibit the apparatus used for skeletal traction in fractures of the os calcis will be presented. Stress is made on the necessity of restoring the contour of the os calcis as much as possible. Many of the important points in the treatment will be emphasized.

Prevention of Deformity

Wisconsin Rheumatism Association

The first line of defense in the care of rheumatic patients is to diagnose correctly the type of disturbance. The second line of defense is the prevention of deformity. This is of social and economic as well as medical significance.

In this exhibit the prevention of the various types of deformities will be presented. The early recognition of impending deformity will be stressed as well as the technic of deformity prevention which can be employed by a physician interested in rheumatism.

Pyloric Stenosis

A. A. Schaefer, assistant clinical professor of surgery, Marquette University School of Medicine, Milwaukee; and H. W. Hefke, Milwaukee

The exhibit consists of posters indicating the diagnosis of pyloric stenosis and anatomic studies of the pylorus in both normal infants and those having hypertrophic pyloric stenosis. The photographs are of the normal pyloric muscle and microphotographs of normal muscle and hypertrophic pyloric stenosis. There are roentgenograms of the pylorus and stomach of healthy infants and of infants with hypertrophic pyloric stenosis. In the latter, there is always a ronentgenologically demonstrable filling defect in the pyloric region which corresponds to the tumor. The pyloric opening time is of some importance while size, shape, and emptying time of the stomach are of practically no importance for the roentgen diagnosis. The roentgen examination is very reliable if certain technical factors are strictly adhered to. In 50 cases with surgically proved pyloric stenosis, the roentgen examination had demonstrated the presence of it. In no cases with a roentgenologically normal stomach was a tumor found at operation. Roentgen examination in questionable cases of hypertrophic pyloric stenosis is a very reliable and not often enough used diagnostic method.

Cancer and the Women's Field Army

Wisconsin Division, Women's Field Army

The four exhibits to be shown are of a newer, more challenging calibre than those used in previous years. They are in keeping with the educational program of the Women's Field Army and the 1943 slogan, "With your Aid We shall Be Victorious in the War on Cancer".

The exhibits are titled:

"War on Cancer Must Go On," "Safe Weapons against Cancer," "Delay Kills," and "Cancer is always an Emergency."

Physicians may recall seeing the exhibits pictured in the April 1943 issue of the Field Army Bulletin. If members of the Society are not receiving their copy, please drop a card to the editor, Mrs. G. E. Stoddart, Beaver Dam, Wisconsin. Every Wisconsin Society member should be in receipt of the Bulletin. It is a state specific project and has three objectives: (1) to keep the members in touch with Women's Field Army, (2) to serve as a medium of exchange of ideas and working plans for the officers, and (3) to bring factual cancer information to the lay members of the Wisconsin Division. In addition to the posters, the latex models will be shown.

Medical Literature For Loan

Gladys Ramsey, Librarian, Medical Library Service, Madison

The library exhibit will feature late editions of books and journal articles on industrial medicine and hygiene, tropical diseases, military surgery, chemical warfare, war neuroses, and rehabilitation.

Sample reference requests received during the previous year will be posted. Envelopes of letters received from Wisconsin physicians stationed at various army posts will be displayed.

Available for free distribution will be the usual lists of periodicals and new books added to the Medical Library Service at the University of Wisconsin during 1942 and 1943.

Automobile Drivers Clinic

Wisconsin Motor Vehicle Department, Madison

The "drivers' clinic," an exhibit of the safety division of the state motor vehicle department, is composed of a dozen varied tests to determine driving capabilities.

A large share of the tests are devoted to examination of the eyes for color blindness, depth perception, distance judgment, field of vision, visual acuity and reaction to headlight glare. A reactometer machine is used to determine braking reaction time and ability to coordinate eye and hand movements in steering. Knowledge of fundamental Wisconsin traffic laws is tested on a device which permits one to answer "yes or "no" to a series of questions, with a red light flashing on for an incorrect answer, an orange light for two incorrect answers and a gong ringing if three questions are wrong. All correct answers are given the green light.

This clinic has been in operation for six years, visiting high schools, teachers' colleges, conventions, fairs, and industrial firms. While the CCC camps were in operation, the clinic was used to test every CCC driver in the state of Wisconsin. During the past school year, the clinic was set up for two-day and three-day stands in numerous high schools offering driver education courses.

Accurate Reporting of Births

State of Wisconsin Board of Health, Madison

The physician's responsibility in filling out birth certificates promptly, accurately, and completely is the theme of the exhibit being prepared by the Wisconsin State Board of Health for the Annual Meeting of the State Medical Society.

Each month the Bureau of Vital Statistics finds it necessary to question approximately 500 physicians for items omitted from original birth and death records. Doctors available for civilian practice are decreasing in number daily. Their time is becoming increasingly limited. To conserve that time, concrete suggestions will be made. A large birth certificate will be featured, with lighting effects and other attention getting devices drawing attention to the items on the certificate that are most frequently omitted by doctors in attendance at births.

One of the requirements for gaining access to war industries and for obtaining certain positions in the armed services is proof of United States ciitzenship. The birth certificate is that proof, and the physician sets in motion the machinery for providing it. These and other uses of the birth certificate are brought out in the exhibit.

Spread and Control of Tularemia

American Medical Association, Chicago

Over a ten year period, 300 cases of tularemia were reported in Wisconsin. Rabbits are the most prolific source of infection of the disease in the United States, being responsible for over 90 per cent of human infections. Other animals and birds, which are potential sources of danger, include the coyote, woodchuck, opossum, ground squirrel, sage hen, quail, ruffed grouse, sharp-tailed grouse, tree squirrel, skunk, muskrat, wild rat (in California), and field mouse (in California). The wood tick is responsible for the disease in the Northwest and the dog tick in the South. The deer fly transmits the disease also, especially in Utah and the surrounding states.

The best protection against tularemia is obtained by avoiding contact with infected animals. Hunters should avoid rabbits that are sluggish or refuse to run. Persons dressing wild rabbits should wear rubber gloves, if possible. Scratches and abrasions should be disinfected immediately. Rabbit meat for human consumption should be cooked thoroughly to destroy any possible infection.

Pathology of Tularemia

American Medical Association, Chicago

Gross lesions of tularemia vary somewhat in different animals. In the guinea pig they resemble bubonic plague. The site of infection is necrotic; the contiguous lymph glands are hemorrhagic or caseous, while the secondary chain of lypmh glands may be caseous.

Lesions are found chiefly in the regional lymph nodes, spleen, liver, lungs and kidneys. The disease is essentially a necrotizing process which causes areas of focal necrosis. Such areas may be small as in the liver and spleen. The spleen may be thickly studded with miliary necrotic granules, so thick that at times large areas of the spleen are necrotic. In the lungs, early roentgenograms present a cloudiness; the subsequent pulmonary abscesses are large and necrotic.

Diseases Transmitted From Animals to Man

American Medical Association, Chicago

Several score of infections and infestations are transmitted from animals to man. The cow is a prolific source of such diseases, the most serious

being tuberculosis and brucellosis. The horse spreads glanders, anthrax, encephalomyelitis and half a dozen other diseases. The hog is responsible for trichinosis, swine erysipelas and numerous other troubles. Sheep and goats spread several diseases, among the most serious of which is brucellosis. The dog, because of his intimate contact with man, is responsible for many infections, rabies being the most serious. The cat likewise has intimate contact with children and is responsible for a dozen diseases. The rat is public enemy number one with bubonic plague leading all other infections. Other rodents, which transmit diseases, include rabbits, ground squirrels, tree squirrels, chipmunks, prairie dogs, woodchucks and muskrats. Poultry and other birds transmit several diseases, the most serious being psittacosis from parrots and other pet birds. Many wild animals harbor diseases which might infect man, but the rather remote contact prevents most such infections.

Botulism

American Medical Association, Chicago

Clostridium botulinum is widely distributed in the soil everywhere. It produces the most powerful poison known, being twenty times more powerful than cobra venom, 300 times more powerful than strychnine and 10,000 times more powerful than potassium cyanide.

There are several types of the organism, type A causing most of the American outbreaks from canned foods. Since 1899, there have been 284 outbreaks of botulism, of which 267 were due to home canned foods. For nearly twenty years there have been no cases of the disease, with one possible exception, attributd to commercially canned food. Among the foods canned at home, string beans lead all the rest and are responsible for more than one-third of the outbreaks.

Botulism is an intoxication and not an infection. It has an incubation period of from one to two days with a gradual onset. Vomiting occurs in about one-third of the cases. Diarrhea is uncommon, and abdominal pains are absent. The temperature is subnormal. The nervous system is involved with double vision, difficulty in swallowing, weakness, and respiratory paralysis. The symptoms are protracted and progressive with convalescence slow. The mortality in American cases has been 65 per cent.

Hearing Aids, Their Use and How They Work

Council on Physical Therapy, American Medical Association, Chicago

Hearing aids are becoming more popular for helping the hard of hearing to understand speech. The modern vacuum tube hearing aid is essentially a small radio set, but so compact that it may be carried conveniently on one's person. Small batteries energize the set and are carried in the pocket. The vacuum tube hearing aid has been developed within the last five years. Some physicians may not have had the time to keep abreast with the developments. In this exhibit, an opportunity is provided to study some of the problems associated with the hearing aids. By means of charts and apparatus the make-up and physical characteristics of a hearing aid will be described. Demonstrational lectures will be presented at announced hours. The hearing aid will be dissected, as it were, and each component part described in simple language. Problems relating to fitting of hearing aids, servicing of them, and availability of batteries will be considered.

Endocrine Regulation of Growth

W. O. Thompson, associate professor of medicine, University of Illinois College of Medicine, Chicago; and N. J. Heckel, Chicago; and Lieutenant R. P. Morris, Chicago

This exhibit will illustrate variations from the normal in growth associated with hypofunction and hyperfunction of glands of internal secretion, with special emphasis on stimulation of growth with chorionic gonadotropin and sex hormones. It will be shown that except for the thyroid hormone in patients with childhood myxedema, chorionic gonadotropin and male sex hormone are the most potent stimulators of growth available at present. They stimulate not only the growth of the skeleton, but also the growth of every tissue in the body, in particular the musculature. They are, in other words, general growth stimulators.

Degenerative and Pathologic Changes in Lumbosacral Intervertebral Disks

R. K. Ghormley, professor of orthopedic surgery, University of Minnesota Graduate School, Rochester; and M. B. Coventry, Rochester

This is an exhibit of lumbosacral disks through the various decades of life showing degenerative changes and pathologic specimens of disks which have been removed at autopsy.

Kraurosis Vulvae and Allied Affections

L. M. Randall, associate professor of obstetrics and gynecology, University of Minnesota Graduate School, Rochester; and M. C. Piper, assistant professor of medicine, University of Minnesota Graduate School; and L. A. Brunsting, assistant professor of dermatology and syphilology, University of Minnesota Graduate School, Rochester

This exhibit consists of wax models, colored photographs, photomicrographs, and short histories and findings demonstrating kraurosis and allied lesions of the vulva.

Use of Fascia Lata in Repair of Hernias

James C. Masson, professor of surgery, University of Minnesota Graduate School, Rochester

This is an exhibit of models, transparencies, photographs, and instruments showing the technic of obtaining the preparation and the use of living sutures (fascia lata) in the repair of various types of hernias, such as inguinal hernias, postoperative abdominal hernias, diaphragmatic, umbilical and vaginal hernias.

Diagnosis of Addison's Disease

E. J. Kepler, associate professor of medicine, University of Minnesota Graduate School, Rochester; and M. H. Power, Ph. D., and F. J. Robinson, Rochester

This is an exhibit illustrating methods adapted to the diagnosis of Addison's disease, with special attention paid by the exhibitor to the "water test."

Some Relationships of the Thyroid and Pituitary Glands to Iodine Metabolism

A. S. Chapman, Rochester; and S. F. Haines, associate professor of medicine, University of Minnesota Graduate School, Rochester

This is an exhibit demonstrating results obtained in a study of certain thyroid pituitary relationships in experimental animals, data showing that iodine in the thyroidless animal has a significant effect on growth and basal metabolic rate, and evidence indicating that the thyroid may respond to the stimulus of low iodine in the absence of the pituitary gland. Photomicrographs of pituitary glands demonstrate that different iodine levels in the body may affect the hypophysial cytology in the absence of the thyroid gland.

WISCONSIN RADIOLOGICAL SOCIETY

The Section on Radiology of the Society will present a series of exhibits in three booths at the meeting. Radiologic studies will be presented by individual members of the Section. It is anticipated that upwards of sixty radiographs will be included in the exhibit.

Venography of Lower Extremity

Department of Radiology, Mount Sinai Hospital, Milwaukee

This exhibit will show the visualization of the veins in the lower extremity and will illustrate the application of venography in the diagnosis and treatment of thrombophlebitis of the lower extremity.

Localized Paget's Disease

E. E. Seedorf, Saint Francis Hospital, La Crosse

This exhibit will demonstrate the fact the Paget's disease may be a localized phenomenon for a considerable time.

The Obturator Line—A Sign for Early Diagnosis of Inflammatory Disease of the Hip

Hans W. Hefke, Milwaukee Hospital, Milwaukee

A demonstration of a new sign in the diagnosis of early inflammatory disease in the hip in children. The anatomic and radiographic features will be shown. This exhibit will be shown in conjunction with Dr. V. C. Turner.

Roentgen Analysis of Skull Fractures

L. W. Paul, Department of Radiology, University of Wisconsin, Madison

This exhibit will present a series of fractures of the skull to demonstrate different types, the importance of technic in taking the roentgenogram, and the necessity for special projections in certain instances. A portion of the transparencies will be devoted to demonstrating conditions that appear to be fractures but which are not.

X-Ray Evidence of Old Previously Unrecognized Fractures

J. E. Habbe, H. H. Wright, G. H. Larson

This exhibit will illustrate the various fractures as to type and location which are still escaping detection in the hands of the attending physician, the history of a number of these patients indicating that roentgenography was not carried out or requested by the attending physician, and, in some instances, the patient did not seek medical care, apparently being so little inconvenienced or suffering such relatively slight pain as to consider it unnecessary to consult a physician. Fractures of both the upper and lower extremity and even several fractures of the spine will comprise the exhibit.

The X-Ray Characteristics of Pneumonia

S. A. Morton, Columbia Hospital, Milwaukee

A roentgenographic demonstration of the various types of pneumonia seen in practice. The localization of the affected area in the lung will be demonstrated and some points in differential diagnosis shown.

Diseases of Gynecological System

Arnold S. Jackson, Jackson Clinic, Madison

This is an exhibit of moulages, transilluminated colored drawings, roentgenograms, and photographs showing: (1) Gynecologic anatomy with simple views of the uterus and ovaries, illustrations of the blood circulation and lymphatics with drawings of the gential organs in relation to the pelvis. (2) Diseases of the uterus, illustrated by wax models prepared from the original specimens removed at time of operation. Cancer of the uterus, a sessile submucous tumor, myoma with cystic degeneration, and a multiple fibroid tumor are shown. A series of drawings—sagittal section of the pelvis depicts cases of malpositions of the uterus with that of the normal. (3) Diseases of the ovaries are shown by wax models and drawings as studies of the different

types of ovarian cysts and tumors. (4) Diseases of the fallopian tubes, specific and nonspecific, with illustrations of different types. Plates showing diagnostic method of lipidol injection into the genital organs. (5) Cesarean section followed by abdominal hysterectomy presented by drawings in surgical step form used in the particular method of this operation. Wax models made of the fibroid tumor and placenta and photograph taken of the living baby at time of the operation.

Rationale of Bile Salt Therapy

A. C. Ivy, professor of physiology and professor of pharmacy, Northwestern University Medical School, Chicago

This is an exhibit of charts, posters, and graphs illustrating the results obtained from the administration of various therapeutic substances such as bile salts, alcohol, cinchophen, and others. Correlation of these results with medical problems in liver, gallbladder, and biliary tract disease will be made. Roentgenograms of the gallbladder under the action of various emptying substances will be shown. The effect of blood flow on the formation of bile and a model of a thermostromuhr will be demonstrated. There will be a display of all the known and currently used bile salts, both synthetic and naturally isolated.

Obstetrical Hemorrhage

F. H. Falls, professor of obstetrics and gynecology, University of Illinois College of Medicine, Chicago

The exhibit consists of models, charts, and drawings depicting the etiology, diagnosis, and treatment of various forms of obstetric hemorrhages. The models and drawings are for the most part life size and in color. The models are made in bas relief and cover in detail placenta previa, premature detachment of the placenta, postpartum hemorrhage, and hemorrhage incidental to various forms of abortion. Various forms of antepartum fetal hemorrhage are also shown. Ruptured uterus and the treatment of the associated shock and hemorrhage is presented.

The principles on which the management of obstetric hemorrhage depend are presented in the form of lettered charts, as well as statistic material.

The purpose of the exhibit is to furnish to medical men, graduate and undergraduate, and to nurses authentic information regarding the etiology, pathology, diagnosis, and treatment of obstetric complications associated with abnormal hemorrhage, to the end that they may find themselves better equipped to combat these serious emergencies, which in many if not most cases present themselves to the medical attendant without warning and in which speedy application of the proper remedies is the essence of treatment.

Medical Treatment of Civilian Gas Warfare Casualties

E. L. Belknap, associate clinical professor of medicine, Marquette University School of Medicine, Milwaukee; and A. R. Curreri, assistant professor of surgery, University of Wisconsin Medical School, Madison

The object of this exhibit is to show the members of the State Medical Society the amount of destruction resulting from enemy planes employing gas for a few seconds. The gases that the enemy may employ will be demonstrated. Colored lantern slides will show the gross and microscopic pathologic changes resulting from a chemical warfare attack.

It is obvious that a small exhibit can not completely discuss the treatment of these casualties. However, several posters will be presented which will ask questions relative to first aid and treatment. Anyone capable of answering these questions need not attend the postgraduate school on chemical warfare. On the other hand, those who are unable to answer these questions owe it to their communities, their patients, and themselves to attend the postgraduate chemical warfare schools that will be given in various cities of the state the latter part of September and first part of October.

Induction Center Referral Service

Wisconsin Anti-Tuberculosis Association

The WATA exhibit this year will be a three-panel exhibit with a table and attendant in the foreground, the whole affair presenting some results of the Induction Center Referral Service for Wisconsin boys rejected from the armed services.

The center panel will display two or more pictographic charts showing reported causes of rejection from several thousand young men and the percentages referred to various agencies, with the great majority being referred to family physicians. Numerical breakdowns of referrals to physicians will serve as a sort of Gallup poll of existing patient-physician relationships of this group. Those under medical care, those referred to a physician of choice, referrals to the Milwaukee County Physicians Service Bureau, and those referred to a public health nurse or department for steering to a local physician are some of the significant divisions.

The two side panels will show a man in uniform and the headline, "We know what happens to these," and a man rejected at induction with the headline, "but what happens to these?" The figures may be either life-sized cardboard silhouettes or fully dressed clothiers' models.

Examples of history cards, referral slips, and the resulting key-sort-card file in which the information is correlated will be shown. A special file of tuberculosis cases, their referrals, follow-ups, and eventual disposals will also be presented at the table.

Vocational Training of the Blind

Mr. R. E. Long, Superintendent, School for the Blind, Janesville

The Braille System. Contrary to popular opinion, this is not a system of raised print-letter outlines but is a system of embossed dots. Out of a combination of six dots, the letters of the alphabet, signs, symbols, etc., are made up for reading and writing, mathematical notation, and musical scores. Methods of writing and samples of printed braille material will be presented.

Special Equipment. Educational methods for teaching visually handicapped students are much the same as in the public schools, except that one must keep in mind that much knowledge gained by the average youngster through the eyes must be secured by the blind student through the sense of touch. Equipment will be shown such as wooden maps, with removable states and countries, specially surfaced to show physical differences. Some models will be shown which are "pictures" to blind students.

In the recreational field, especially adapted games and playing cards marked in braille will be shown.

Vocational and Industrial Training. In these fields, the school includes work in basketry, chair seating, rug weaving, broom and brush making, typing and dictaphone, cooking and sewing. Completed projects and demonstrations will be presented from these departments.

Medical Program. In addition to the educational program, the school strives to maintain a complete program of general medical services, with particular emphasis on the preservation and restoration of vision. Charts and statistics will be presented showing frequency and causes of blindness, in addition to disease prevention by tests and immunizations.

School authorities in attendance at the exhibit welcome you and will be glad to answer any questions about the school and work for the blind in general.

Obstetric Manikin Demonstrations

Wisconsin Society of Obstetricians and Gynecologists. William F. Mengert, associate professor of obstetrics and gynecology, State University of Iowa College of Medicine, Iowa City; Morris E. Davis, associate professor of obstetrics and gynecology, University of Chicago, The School of Medicine, Chicago, and Carl P. Huber, associate professor of obstetrics, Indiana University School of Medicine, Bloomington–Indianapolis

At the invitation of the Wisconsin Society of Obstetricians and Gynecologists, W. F. Mengert, M. E. Davis, and C. P. Huber will, in accordance with the schedule set forth below, demonstrate and discuss with registrants at the meeting the subjects selected by R. E. Campbell and W. C. Keettel, under whose supervision the exhibit was arranged. All demonstrations will be conducted in the scientific exhibit hall.

Morning discussion each day will be devoted to an explanation of the use of forceps, demonstrating the various types of forceps and the indications and contraindications for their use, including the management of occiput posterior and the various methods of treating this presentation.

The afternoon demonstration period each day will be limited to a discussion of the management of breach presentation with a demonstration of the various methods of delivery, also a discussion of version and extraction.

Monday—September 13
10:00–10:30 a.m.
3:00– 3:30 p.m.
William F. Mengert

Tuesday—September 14
10:00–10:30 a.m.
3:00– 3:30 p.m.
Morris E. Davis

Wednesday—September 15
10:00–10:30 a.m.
11:30–12:00 a.m.
Carl P. Huber

SCIENTIFIC MOTION PICTURE THEATER

A. M.
9:30—Malaria
10:00—Plastic Surgery
10:30—Preparation of Plasma
10:45—The Right to Hear
11:30—Crushing Facial Injuries

Technical Exhibitors at One Hundred Second Anniversary Meeting

The Borden Company, New York, New York
Bilhuber–Knoll Corporation, Orange, New Jersey
Rudolph Beaver, Inc., Waltham, Massachusetts
Belgard–Spero, Inc., Milwaukee
S. H. Camp and Company, Jackson, Michigan
The Carnation Company, Oconomowoc
C I B A Pharmaceutical Products, Inc., Summit, New Jersey
Coca Cola Company, Atlanta, Georgia
Conformal Footwear Company, St. Louis
General Electric X-Ray Company, Chicago
Gerber Products Company, Fremont, Michigan
H. J. Heinz Company, Pittsburgh, Pennsylvania
Horlick's Malted Milk Corporation, Racine
Hurley X-Ray Company, Milwaukee
Mead Johnson Company, Evansville, Indiana
Kelley–Koett Manufacturing Company, Covington, Kentucky
The Kellogg Company, Battle Creek, Michigan
Kremers–Urban Company, Milwaukee
Lederle Laboratories, New York, New York
Eli Lilly and Company, Indianapolis, Indiana
J. B. Lippincott Company, Philadelphia
M and R Dietetic Laboratories, Columbus, Ohio
Medico-Mart, Milwaukee
Mellin's Food Company, Boston, Massachusetts
Wm. S. Merrell Company, Cincinnati, Ohio
Philip Morris and Company, New York, New York
C. V. Mosby Company, St. Louis
V. Mueller and Company, Chicago
Pet Milk Sales Corporation, St. Louis
Petrogalar Laboratories, Inc., Chicago
Physicians and Hospitals Supply Company, Minneapolis
Roemer Drug Company, Milwaukee
Sandoz Chemical Works, Inc., New York, New York
W. B. Saunders Company, Philadelphia.
Schering Corporation, Bloomfield, New Jersey
G. D. Searle and Company, Chicago
Sharp and Dohme, Philadelphia
Smith, Kline and French Laboratories, Philadelphia
S. M. A. Corporation, Chicago
E. R. Squibb and Sons, New York, New York
U. S. Hospital Supply Company, Minneapolis
U. S. Standard Products Company, Woodworth.
White Laboratories, Inc., Newark, New Jersey
Winthrop Chemical Company, Inc., New York, New York
John Wyeth and Brother, Inc., Philadelphia

ON THE DOT

The scientific program is conducted so that the speakers appear on the program on the dot. You can be assured that each speaker will present his paper at the time scheduled and printed in the program.

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. E. S. Schmidt, Green Bay, President
Mrs. H. E. Twohig, Fond du Lac, President-Elect
Mrs. R. B. Dryer, Poynette, Vice-President
Mrs. R. M. Kurten, Racine, Recording Secretary
Mrs. L. D. Quigley, Green Bay, Corresponding Secretary
Mrs. Charles Fidler, Milwaukee, Treasurer
Mrs. C. D. Partridge, Cudahy, Parliamentarian

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Mrs. D. F. Gosin, Green Bay
Public Relations—
Mrs. R. D. Champney, Milwaukee
Legislation (special committee)—
Mrs. L. V. Sprague, Madison
Circulation of Bulletin (special committee)—
Mrs. W. A. Wagner, Oshkosh
War Activities (special committee)—
Mrs. A. J. McCarey, Green Bay

Final Plans For Annual Auxiliary Meeting Are Announced

THE task of arranging the program for the fifteenth annual meeting of the Woman's Auxiliary to the State Medical Society has now been completed. When the general meeting opens on Monday morning, each county auxiliary will have representatives present to transact the business of the organization. County presidents will make reports of their societies, and officers and chairmen of standing committees will tell of the work of their departments, so that members may have a complete picture of their Auxiliary's activities.

All members will wish to come to the meeting this year, for one of their own group, Mrs. E. J. Carey of Milwaukee, will be officially greeted as the new national president of the Auxiliary. Physicians' wives who are not members are also invited to attend the functions.

Our state president, Mrs. E. S. Schmidt, is very happy over the acceptance by Rear Admiral Ross T. McIntire, Surgeon General of the Navy, of an invitation to speak at the Monday luncheon. He will discuss "The Accomplishments Made in Lifesaving by the Medical Corps of the Navy in the Present War." It is expected that this luncheon will be very well attended by physicians' wives eager to hear of the work of medical men in the Navy.

The buffet supper on Monday evening, which is given Auxiliary members by the State Medical Society, will be followed by a reception in honor of new national officers. There will also be music and entertainment.

At the Tuesday luncheon there will be round-table discussions of Auxiliary activities and a talk by the national president. Miss Nancy Gray, commentator on radio station WTMJ, will also appear.

Another major function of this convention will be the One Hundred Second Anniversary Dinner of the State Medical Society, which will be held in the Crystal Ballroom of the Hotel Schroeder on Tuesday evening. Dr. R. M. Kurten, president of the State Society, has announced Dr. James E. Paullin, president of the American Medical Association, as the main speaker.

Last September, attendance at the annual dinner was much greater than anticipated, and it is expected that this year physicians and their wives will be greatly interested in Dr. Paullin's talk on "The Role of the Medical Profession in Planning for Postwar Medical Service." Auxiliary members are urged to have their husbands purchase their dinner tickets when they register.

PROGRAM

Sunday, September 12, 1943

P. M.

4:00–7:00 Registration — Hotel Schroeder, Fifth Floor

7:00 Board of Directors' Dinner—Hotel Schroeder
Mrs. E. S. Schmidt, president, presiding

Guests

Past-presidents, Woman's Auxiliary to the State Medical Society of Wisconsin

Wisconsin's three national officers: Mrs. E. J. Carey, Wauwatosa, president; Mrs. Charles Fidler, Milwaukee, corresponding secretary; Mrs. O. W. Friske, Beloit, program chairman

Reports of state chairmen

Monday, September 13, 1943

A. M.

10:00 General Meeting — Club Rooms, Hotel Schroeder
Mrs. E. S. Schmidt, president, presiding
Invocation—Reverend F. M. Sheldon, Grand Avenue Congregational Church, Milwaukee
Auxiliary Pledge
Convention Announcements
Address of Welcome—Mrs. F. R. Janney, president, Woman's Auxiliary to the Medical Society of Milwaukee County
Response — Mrs. H. E. Twohig, president-elect, Woman's Auxiliary to the State Medical Society of Wisconsin
In Memoriam
Convention Rules and Procedure—Mrs. C. D. Partridge, parliamentarian
Minutes of Annual Meeting, 1942
Reports of State Officers
Reports of County Auxiliary Presidents
Report of Chairman, Committee on Credentials and Registration
Address—"Activities in the State Office"—Mr. C. H. Crownhart, secretary, State Medical Society of Wisconsin
Announcements

P. M.

1:00 Luncheon—Empire Room, Hotel Schroeder
Greetings — Dr. R. M. Kurten, president, State Medical Society of Wisconsin
Address—A Review of the Accomplishments Made in Lifesaving by the Medical Corps of the Navy in the Present War — Rear Admiral Ross T. McIntire, Surgeon General of the United States Navy, Washington, D. C.

7:00 Buffet Supper and Reception—Banquet Room, Hotel Schroeder (Courtesy, State Medical Society of Wisconsin)
Guests of Honor—Mrs. E. J. Carey, national president, and her national board members, Mrs. Charles Fidler and Mrs. O. W. Friske
Entertainment—Mrs. Myra Peache
Current New York Plays
Music

Tuesday, September 14, 1943

A. M.

10:00 General Meeting — Club Rooms, Hotel Schroeder
Mrs. E. S. Schmidt, president, presiding
Business Session
Election of Officers
Induction of the President, Mrs. H. E. Twohig
Installation of New Officers
Announcements
Report of Chairman of Committee on Credentials and Registration

11:30 Post-Convention Meeting—Board of Directors —Club Rooms, Hotel Schroeder
Mrs. H. E. Twohig, president, presiding

P. M.

1:00 Luncheon—Banquet Room, Hotel Schroeder
Round-Table Discussions of Auxiliary Activities
County Presidents — Mrs. F. R. Janney, Milwaukee
Treasurers — Mrs. Charles Fidler, Milwaukee
Archives—Mrs. J. P. Connell, Fond du Lac
Finance—Mrs. J. R. Minahan, Wauwatosa
Hygeia—Mrs. A. C. Taylor, Appleton
Philanthropic—Mrs. S. O. Lund, Cumberland
Program—Mrs. D. F. Gosin, Green Bay
Press and Publicity—Mrs. D. B. Dana, Kewaunee
Public Relations—Mrs. R. D. Champney, Milwaukee
Circulation of *Bulletin*—Mrs. W. A. Wagner, Oshkosh
Legislation—Mrs. L. V. Sprague, Madison
War Activities — Mrs. A. J. McCarey, Green Bay
Address—"The Auxiliary War Participation Program" — Mrs. E. J. Carey, national president
Entertainment—Miss Nancy Gray, commentator, Radio Station WTMJ
Music—Songs by Mrs. Richard Tyrrel, accompanied by Mrs. Joseph Tolan

6:45 Informal Banquet, State Medical Society of Wisconsin — Crystal Ballroom, Hotel Schroeder
"The Role of the Medical Profession in Planning for Post-War Medical Service"—Dr. James E. Paullin, president, American Medical Association

Annual Meeting Committees*

Executive Committee
Mrs. H. O. Zurheide, chairman
Mrs. H. J. Cannon, co-chairman (Social)
Mrs. N. W. Bourne, co-chairman (Program)

Headquarters—Reception
Mrs. R. D. Champney
Mrs. T. M. Northey

Hostesses
Officers and Members of the Board of Directors of the Woman's Auxiliary to the Medical Society of Milwaukee County:
Mrs. F. R. Janney, Wauwatosa, president
Mrs. E. F. Barta, Wauwatosa, president-elect
Mrs. H. A. Heise, vice-president
Mrs. H. O. Zurheide, past-president
Mrs. C. W. Osgood, Wauwatosa, recording secretary
Mrs. T. M. Northey, corresponding secretary
Mrs. R. P. Schowalter, Wauwatosa, treasurer
Mrs. R. E. Fitzgerald, Wauwatosa, parliamentarian
Mrs. G. H. Hoffman, West Allis, director
Mrs. T. L. Squier, director
Mrs. Irwin Schulz, Wauwatosa, director
Mrs. T. S. O'Malley, director
Mrs. J. G. Taylor, director
Mrs. U. A. Schlueter, director

Registration and Credentials
Mrs. E. F. Barta, Wauwatosa, chairman
Mrs. R. P. Schowalter, Wauwatosa, co-chairman
Mrs. W. F. Grotjan
Mrs. P. A. Lee
Mrs. H. K. B. Allebach
Mrs. M. W. Sherwood
Mrs. Frank Rettig

Reservations
Mrs. E. P. Bickler, chairman
Mrs. R. O. Brunkhorst, co-chairman
Mrs. C. F. McDonald
Mrs. J. P. Fetherston
Mrs. F. J. Kozina

Publicity
Mrs. W. M. Jermain
Mrs. R. E. McDonald

Convention Hall
Mrs. E. J. Behnke, chairman
Mrs. D. D. Frawley, co-chairman
Mrs. A. S. Kult, Wauwatosa
Mrs. G. E. Thill, Wauwatosa

Flowers
Mrs. J. J. Adamkiewicz, chairman
Mrs. Joseph Lettenberger, co-chairman
Mrs. J. C. Grill
Mrs. R. E. Stockinger
Mrs. A. R. Langjahr
Mrs. E. M. Lawler

Monday Luncheon
Mrs. F. D. Murphy, chairman
Mrs. W. J. Scollard, co-chairman
Mrs. C. J. Becker
Mrs. C. E. Belleheumer
Mrs. R. W. Blumenthal
Mrs. Charles Fidler
Mrs. A. R. F. Grab
Mrs. H. J. Gramling
Mrs. O. R. Lillie
Mrs. W. J. Murphy
Mrs. H. W. Sargent
Mrs. U. A. Schlueter
Mrs. T. L. Squier
Mrs. R. G. Washburn
Mrs. S. M. Markson
Mrs. C. D. Partridge
Mrs. A. J. Ruppenthal

Monday Evening—Supper and Reception
Mrs. H. J. Heeb, chairman
Mrs. H. J. Cannon, co-chairman
Mrs. E. F. Barta
Mrs. R. D. Champney
Mrs. F. G. Connell, Oshkosh
Mrs. R. E. Fitzgerald
Mrs. S. E. Gavin, Fond du Lac
Mrs. H. J. Gramling
Mrs. F. R. Janney
Mrs. W. M. Jermain
Mrs. R. E. McDonald
Mrs. C. D. Partridge
Mrs. J. C. Sargent
Mrs. E. S. Schmidt, Green Bay
Mrs. Rock Sleyster
Mrs. J. G. Taylor
Mrs. R. G. Washburn
Mrs. H. O. Zurheide

Tuesday Luncheon
Mrs. H. J. Cannon, chairman
Mrs. E. J. Schelble, co-chairman
Mrs. B. J. Baumle
Mrs. E. A. Brzezinski
Mrs. N. F. Dettmann, Wauwatosa
Mrs. U. J. Durner
Mrs. Norbert Enzer
Mrs. T. J. Howard
Mrs. John Huston
Mrs. T. A. Judge
Mrs. M. J. Kuhn
Mrs. W. C. Liefert
Mrs. J. R. Regan
Mrs. D. H. Witte
Mrs. G. F. Fitzgerald
Mrs. H. E. Cook
Mrs. M. Q. Howard, Wauwatosa

* Unless otherwise indicated, committee members are from Milwaukee.

Delegates and Alternate Delegates to the Fifteenth Annual Meeting of Woman's Auxiliary to the State Medical Society of Wisconsin*

County	*Delegate*	*Alternate*
Ashland–Bayfield–Iron	Mrs. C. J. Smiles	Mrs. J. W. Prentice
	Mrs. W. J. Tucker	
Brown–Kewaunee–Door	Mrs. T. S. Burdon	Mrs. P. R. Minahan
	Mrs. E. S. McNevins	Mrs. W. T. Hagerty
Columbia–Marquette–Adams	Mrs. J. H. Houghton	Mrs. H. E. Gillette
	Mrs. L. V. McNamara	Mrs. H. M. Caldwell
Crawford	Mrs. O. E. Satter	Mrs. G. R. Hammes
	Mrs. E. M. Dessloch	Mrs. E. T. Ackerman
Dane	Mrs. L. V. Sprague	Mrs. H. L. Greene
	Mrs. A. R. Curreri	Mrs. C. N. Neupert
Fond du Lac	Mrs. E. V. Smith, Jr.	Mrs. J. S. Huebner
	Mrs. S. E. Gavin	Mrs. L. J. Keenan
Marinette–Florence	Mrs. J. D. Zeratsky	Mrs. R. W. Shaw
	Mrs. J. V. May	Mrs. H. L. Jorgenson
Milwaukee	Mrs. F. R. Janney	Mrs. E. F. Barta
	Mrs. H. A. Heise	Mrs. P. A. Lee
	Mrs. U. A. Schlueter	Mrs. M. J. Bach

* No reports were received from county societies not listed.

County	Delegate	Alternate
Milwaukee	Mrs. S. M. Mollinger	Mrs. U. E. Gebhard
	Mrs. Edward Jackson	Mrs. T. J. Howard
	Mrs. J. O. Dieterle	Mrs. C. E. Bellehumeur
	Mrs. W. A. Brussock	Mrs. A. H. Goodsitt
	Mrs. R. T. Gilchrist	Mrs. E. F. Guy
	Mrs. G. P. Dempsey	Mrs. A. H. Hermann
Outagamie	Mrs. A. E. Rector	Mrs. C. D. Neidhold
Racine	Mrs. R. M. Kurten	Mrs. H. G. Brehm
	Mrs. C. F. Browne	Mrs. J. M. Albino
Rock	Mrs. H. E. Kasten	Mrs. E. C. Hartman
Sheboygan	Mrs. G. J. Hildebrand	Mrs. J. F. Kovacic
	Mrs. V. F. Neu	Mrs. W. W. Van Zanten
Washington–Ozaukee	Mrs. J. E. Reichert	Mrs. H. M. Lynch
	Mrs. P. B. Blanchard	Mrs. R. Fisher
Waukesha	Mrs. E. L. Lochen	Mrs. Henry Peters
	Mrs. J. C. Hassall	Mrs. H. T. Barnes
Waupaca–Shawano	Mrs. R. K. Irvine	Mrs. J. W. Monsted
	Mrs. E. A. Miller	Mrs. H. C. Schmallenberg
Winnebago	Mrs. W. A. Wagner	Mrs. E. B. Pfefferkorn

Appointments and Reappointments to State Public Health Bodies

State Board of Medical Examiners

ACTING-GOVERNOR Walter S. Goodland has recently announced the appointment of Dr. John W. Smith, Milwaukee, to the State Board of Medical Examiners. Dr. Smith is a graduate of the Marquette University School of Medicine and is a specialist in dermatology. He is a member of the American Academy of Dermatology and Syphilology. In 1942 he served as delegate from the Medical Society of Milwaukee County to the annual meeting of the State Medical Society.

JOHN W. SMITH

Also announced are the reappointments to the State Board of Medical Examiners of Drs. R. G. Arveson, Frederic; J. P. Allen, Beloit; and C. A. Dawson, River Falls, all of whose terms are expiring at this time.

JESSIE P. ALLEN

State Board of Health

Dr. Gunnar Gundersen, La Crosse, has been reappointed to the State Board of Health and has been elected by that Board to serve as its president. Dr. Gundersen was appointed by the Governor last January 15 to fill out the unexpired term of Dr. C. A. Harper, who had resigned from the Board. Dr. Gundersen's new term will begin in February, 1944, and will expire in February, 1951.

GUNNAR GUNDERSEN

Minutes of the Council; Madison, July 18, 1943

The entire Council and invited guests were present at the Executive Mansion, Madison, upon invitation of Acting-Governor Walter S. Goodland on the evening of Saturday, July 17. An informal evening of discussion of various subjects was enjoyed, the chief topic being that of the public health of the citizens of Wisconsin, wartime problems, and postwar rehabilitation problems. A most enjoyable evening was had by all present.

. Call to Order

The Council convened at 9:00 a. m., Sunday, July 18, 1943, at the Hotel Loraine, Madison.

. Roll Call

The following were present, constituting a quorum: Councilors Gavin, Hough, Pechous, Clark, Pippin, Heidner, Jegi, Christofferson, Arveson, Fitzgerald, Blumenthal and Leahy; President Kurten; Past-President Gundersen; Speaker Fidler; Vice-Speaker Minahan; Treasurer Sisk; Delegate Smith; Alternate Delegate Rector; Secretary Crownhart and Assistant Secretary Larson. Invited guests were Doctors J. S. Supernaw, State Chief of Emergency Medical Service under Civilian Defense; G. G. Stebbins, secretary, Dane County Medical Society; Eben . Carey, president, The Medical Society of Milwaukee County and John McCabe, president-elect of that Society; C. N. Neupert, State Health Officer; C. A. Dawson, chairman, Committee on Public Policy, and Mr. James O. Kelley, executive secretary, The Medical Society of Milwaukee County. Council members absent: Doctors Krahn and Eberbach.

. Approval of Minutes of January Meeting

It was moved by Fitzgerald-Pechous that the minutes of the January meeting of the Council, as published in the March issue of *The Wisconsin Medical Journal*, be approved. Motion carried.

. Councilor Leahy

Chairman Gavin introduced the new councilor from the Thirteenth District, Dr. J. D. Leahy, Park Falls, and reported a card of thanks from Mrs. F. E. Butler for the expression of sympathy from councilors and officers at the time of the death of Dr. Butler, president of the State Medical Society of Wisconsin.

Mr. Crownhart read a communication from Dr. Olin West, secretary of the American Medical Association, in which he expressed interest in the minutes of the Council of the State Medical Society and the thoroughness and detailed care given by the Council members to the Society's affairs.

. Committee on War Records

Secretary Crownhart explained that the Wisconsin Council of Defense had asked that various state organizations take such steps as are feasible to maintain the war records of members of these organizations who may be in service. He further stated that councilors might be interested in knowing that the State Medical Society maintains a file on every member in service and that all items, such as news items, go into those files. After discussion, upon motion by Arveson–Jegi, it was decided that the chairman of the Council should appoint the committee, to consist of not more than three members.

6. Reports of Delegates to the American Medical Association

Delegate Smith gave a detailed discussion of the most important action taken by the House of Delegates of the American Medical Association, which concerned the proposals introduced by the Minnesota State Medical Society, as well as by other state societies, to somewhat similar extent, that a special Council on Medical Service and Public Relations be created, composed of the president of the American Medical Association, ex officio, the immediate past-president, the secretary, a member of the Board of Trustees, and one member of the American Medical Association to be elected in various geographic districts of the United States. The duties of the council shall be to make available scientific facts and data, and medical opinion, with respect to rendition of medical care, to create medical service committees in state and county societies, and to establish relations with other allied groups.

Delegate Smith reported that the resolution was actively debated, being first adopted and then referred back to the Board of Trustees for action. The Board of Trustees made a report which in some respects changed the original resolution in that it provided, first, that the Board of Trustees would appoint members for the first year, members not already connected with the Board, and then they were to nominate from the delegates certain other persons to be elected.

Dr. Smith further reported that the Wisconsin delegates supported the resolution in its final form, and that it was passed by an overwhelming vote in the House of Delegates.

Dr. Rector, who attended the meeting of the House of Delegates in the capacity of alternate delegate, reported that he was mainly interested in watching the trend of the business that came before the House. It seemed to him that the principal intent for the establishment of the Council on Medical Service and Public Relations involved the creation of an information bureau. Dr. Rector further reported on the dinner given by the Board of Trustees at which the principal speaker was Professor Charles E. Merriam, chairman of the Department of Political Science of the University of Chicago and a member of the United States Planning Board.

7. Report of the Committee on Public Policy

Dr. Dawson gave his report as chairman of the Committee on Public Policy of the State Medical

Society. The Council expressed its thanks to Dr. Dawson by a rising vote.

8. Council on Medical Service and Public Relations

At this point in the proceedings, discussion was had in respect to the obligations now resting upon the State Medical Society in connection with the Council on Medical Service and Public Relations of the American Medical Association. It was moved by Clark–Heidner that the secretary's office perfect machinery to cooperate with the American Medical Association in this matter. The motion was carried.

9. Voluntary Sickness Insurance

Assistant Secretary Larson gave a progress report of the Committee on Medical Economics and Voluntary Sickness Insurance. The current status of negotiations with the Farm Security Administration was presented, and the Council was informed that the Society was now discussing with the Price–Taylor County Medical Society the possibility of establishing a trial plan in that area.

Mr. Kelley, executive secretary of the Medical Society of Milwaukee County, gave a brief report on activities of the surgical benefit plan now being considered in Milwaukee County. He pointed out that no definite program had as yet been formed as it was still uncertain as to what type of care the industrial plant with which they were dealing desired at this time.

President Kurten pointed out the possible problem involved in the importation of migrant workers into Wisconsin.

10. Annual Reregistration

Secretary Crownhart presented some of the background for the enactment of the annual reregistration law and explained the procedure necessary for setting up machinery for its enforcement. Dr. Dawson expressed his concept for the establishment of such machinery, after which the meeting recessed at 12:15 p. m. for dinner.

The Council reconvened at 1:30 p. m., at which time Councilor Christofferson, president of the State Board of Medical Examiners, impressed upon the Council the importance of the annual reregistration act. It was moved by Pechous–Hough that the Society employ special legal counsel at a ceiling of $750. The motion was carried.

11. Election of Councilor from the Eleventh District

This councilor vacancy was created by the death of Dr. T. J. O'Leary last February. The Council appointed Dr. V. E. Ekblad, Superior, to fill the vacancy.

12. Rehabilitation of Veterans

Dr. Dawson, recently appointed to the Veterans' Recognition Board, explained to the Council the object of this board, which is to see that adequate care is provided veterans of World War II who have been incapacitated in the service of their country. He observed that there are already more than 200 men who have been brought back to Wisconsin with mental disorders and have been left in their parents' care. The Board consists of five members appointed by the Governor and confirmed by the Senate together with the Governor himself, who is an ex officio member, and a representative of the Attorney General's staff, also ex efficio. Dr. Dawson suggested that the Council consider the matter of the appointment of an advisory committee to act with the Veterans' Recognition Board. He suggested that the committee be limited to three members. It was moved by Fitzgerald–Christofferson that the chairman of the Council appoint such a committee. The motion was carried.

13. Emergency Medical Service

The chairman called upon Dr. Supernaw, state chief of Emergency Medical Service, to give a report on activities at the present time. Dr. Supernaw advised the Council that the Army has designated certain areas within the state as danger or target areas. Until recently, Emergency Medical Service was set up exclusively on a county level, but under this new arrangement aid is directed primarily to these designated target areas. Many civilians have been critical of the expenditures entailed in securing supplies for Emergency Medical Service, but Dr. Supernaw pointed out that all this material would be of extreme value after the termination of this war.

14. Recommendations to the House of Delegates

Upon motion of Kurten–Christofferson, it was voted to recommend to the House of Delegates that a Committee on Executive Session of the House be authorized.

15. Procurement and Assignment Service

Dr. Fitzgerald, state chairman of the Procurement and Assignment Service for Physicians, presented an extensive report on the present status of this service in Wisconsin. He pointed out that it has been impossible to maintain a state-wide ratio of one physician to 1,500 population. At this time, he remarked, we have no quota established for the state, but we will be expected to supply any quantity of physicians called for by the armed forces.

16. Legal Assistance to the Society

Secretary Crownhart informed the Council that it would be necessary to obtain new legal advice due to the fact that Mr. R. B. Murphy, former legal counsel for the Society, together with his associates, has entered the armed services. He reported that negotiations had been effected to obtain the services of Attorney Francis Lamb of Madison.

17. State Board of Health

Dr. C. N. Neupert, state health officer, reported the current status of communicable diseases in Wisconsin.

18. Adjournment

After standing for a moment in silent tribute to Dr. Francis Butler, the Council adjourned at 3:15 p. m.

Obstetric Care For Wives of Service Men

THE President has approved H.R. 2935, making appropriations for the Department of Labor, the Federal Security Agency and related independent gencies for the fiscal year 1944. This law appro-riates $4,400,000 for grants to states, including Alaska, Hawaii, Puerto Rico, and the District of Columbia, "to provide, in addition to similar services therwise available, medical, nursing, and hospital naternity and infant care for wives and infants of nlisted men in the armed forces of the United States, under allotments by the Secretary of Labor nd plans developed and administered by state ealth agencies and approved by the Chief of the Children's Bureau."

As reported to the House, June 14, H.R. 2935 carried the following proviso to the title of the bill aking appropriations for the Department of abor:

Provided, that no part of any appropriation contained in this title shall be used to promulgate or arry out any instruction, order, or regulation hich discriminates between persons licensed under tate law to practice obstetrics."

The Senate Committee on Appropriations, on June 4, recommended that the proviso be stricken from he bill. Thereafter, the Senate acquiesced in the ecommendation of its committee and passed the ill June 29. A conference committee then considred the bill and agreed to recommend that the proiso be reinserted with the following additional hraseology:

"*Provided further*, that the foregoing proviso hall not be so construed as to prevent any patient rom having the services of any practitioner of her wn choice, paid for out of this fund, so long as tate laws are complied with."

The conference report was considered in the Sente on July 2. There was no vote specifically on the ecommendation of the conferees in connection with he proviso in question, but an effort was made to nduce the Senate to reject the conference report beause of that recommendation. The vote in the Sente was on the adoption of the conference report as whole. Senator La Follette of Wisconsin, Senator odge of Massachusetts, Senator Chandler of Kentucky, Senator Hill of Alabama, Senator Maloney of Connecticut and Senator McClellan of Arkansas argued for the rejection of the conference report because of the recommendation it contained with respect to the proviso. Senator La Follette remarked, in part, as follows:

"Mr. President, I say that to yield on this matter is a step backward in modern practice of obstetrics, and it is unfair to the servicemen, who are preparing to give their lives for their country, if necessary, that their wives, who are pregnant, and who are to be delivered in their absence, shall not have the benefit of the finest standards and the finest care that money can procure.

"Yet in this false application of the so-called doctrine of states' rights such a situation will be created that the Congress will have done that very thing. So far as I am concerned, Mr. President, I want no part of it. I want no father of a child born while the father is overseas fighting for his country to point his finger at me and say, 'You are responsible for the death of my wife and child in my absence, because a man was permitted to minister to her at her time of need who was not properly equipped, who was not licensed to use drugs, who was not licensed to practice surgery.'

"Mr. President, I say such a thing would be an outrage."

After considerable discussion, the Senate voted to adopt the conference report by a vote of 42 to 32, with 22 Senators not voting.

As the bill was approved by the President, therefore, it contains the following proviso in the title relating to appropriations for the Department of Labor:

"*Provided*, that no part of any appropriation contained in this title shall be used to promulgate or carry out any instruction, order, or regulation relating to the care of obstetrical cases which discriminates between persons licensed under state law to practice obstetrics: *Provided further*, that the foregoing proviso shall not be so construed as to prevent any patient from having the services of any practitioner of her own choice, paid for out of this fund, so long as state laws are complied with."

NO REGISTRATION FEE

Because of the revenue received from the technical exhibitors for exhibit space, it is possible for you to attend the One Hundred Second Anniversary Meeting without paying a registration fee. If it were not for this revenue, the per capita cost for physicians attending the meeting would be from $4 to $5.

These firms have a genuine message for you; both the exhibitors and you will be repaid many times if you stop at their booths.

Why Not Better Chest Roentgenograms?

THE Wisconsin Anti-Tuberculosis Association interpreted about six thousand chest roentgenograms for physicians of the state last year. The impression to date is that this number will be exceeded this year. Naturally, these films vary in quality, as they are taken on all kinds of apparatus and under all kinds of conditions. Some are excellent, some are not so good, and a few are impossible to interpret. But it is only fair to state that there has been considerable improvement in the diagnostic quality of the films sent us in the last five years.

With the idea of securing better films, the Association is offering a new service to physicians and hospitals in Wisconsin. This is a demonstration and discussion of chest roentgenographic technic, not by a technician but by a physician who is interested in the subject. It consists of a series of films of the same individual demonstrating good technic and the more common deviations from it. It is personal, in that it is done in the office of the physician or the roentgen ray room of a hospital. The whole physical set-up is inspected, particularly the dark room equipment. This is not done with any idea of trying to sell, or to induce individuals to buy, new apparatus but simply to help in getting the maximum out of the present material.

While the physician would be happy to talk to roentgenologists and roentgen ray technicians of the larger hospitals, the Association is interested chiefly in the physician who is doing his own chest roentgenography or the small hospital which does not have ready access to expert advice.

A few experimental trips have been made. These have shown that there is a definite need for a service of this kind. As an example, several physicians have informed us that they really did not know what a satisfactory chest roentgenogram should be. After being informed, they are surprised how simple, many times, the evaluation really is. Those who have been visited appear not only willing but anxious to have the demonstration made. There is the added advantage of being able to discuss any chest roentgenograms they may have made with a physician who is familiar with the interpretation of chest roentgenograms. Considerable improvement has been noted in the films coming from places which have been visited. There is no charge for this service.

Naturally, the Wisconsin Anti-Tuberculosis Association is interested in having the best possible type of chest roentgenograms sent in for interpretation. Any physician or hospital desiring this type of service may write to Dr. H. F. Ringo, in care of the Wisconsin Anti-Tuberculosis Association, 1018 North Jefferson Street, Milwaukee, 2, Wisconsin.

NATIONAL FOUNDATION FOR INFANTILE PARALYSIS

Twenty-eight grants, totaling $354,370, have been made by The National Foundation for Infantile Paralysis to universities, hospitals, laboratories and other organizations in eleven states to continue the fight against the disease, it was announced recently by Basil O'Connor, president of the Foundation.

The grants were recommended by the Foundation's Medical Advisory Committees at its semi-annual meeting and have now been approved by the Board of Trustees. The funds which make possible the Foundation's program are raised annually in January through the celebration of President Roosevelt's birthday.

Sixteen grants, totaling $216,020, were made for virus and after-effects research. Four of these are on long-term projects being conducted at Yale University, The Johns Hopkins University, the University of Michigan and the University of Wisconsin.

Twelve grants, totaling $138,350, were made for various educational programs including the training of technicians in the Kenny method of treatment. Some of these grants include projects for educational work for physicians and the public. The sum of $2,500 was appropriated for the preparation of a complete bibliography on poliomyelitis. The compilation is being done for the Foundation with the aid of the library of the American Medical Association and the John Crerar Library, both in Chicago.

RECENT WISCONSIN LICENTIATES

The Wisconsin State Board of Medical Examiners, at a meeting held in Madison on January 12, 13 and 14, licensed the following physicians in the practice of medicine after they had successfully passed an examination:

Name	*School of Graduation*	*Year*	*Present Address*
Bechtol, Charles O.	Stanford	1940	2122 University Avenue, Madison.
Behnke, George	Wisconsin	1942	133 Oakland, Oshkosh.
Bischof, Henry F.	Rush	1942	Richland Center.
Clark, Elizabeth A.	Michigan	1940	Wisconsin General Hospital, Madison.
Collins, Royden F.	Wisconsin	1942	739 East Johnson Street, Madison.
Cornille, Alfred J.	Loyola	1942	2548 Coyle Avenue, Chicago.
Dawson, Lorin D.	Wisconsin	1942	% Chester Hospital, Chester, Pennsylvania.
Gollin, Harvey A.	Wisconsin		2840 West 79th Street, Milwaukee.
Hogenson, Clifford D.	Wisconsin	1941	211 North Randall Avenue, Madison.
Jacobs, James S.	Columbia University College of P. & S.	1941	1300 University Avenue, Madison.
Jarvis, Edward C.	Marquette	1942	Hillsboro.
Kindwall, Joseph A.	Johns Hopkins	1927	1220 Dewey Avenue, Wauwatosa.
Lichtor, Nathan A.	Rush	1942	Army Medical Corps.
Stafford, William T.	Wisconsin	1942	Chippewa Falls.
Thill, Charles J.	Michigan	1940	1405 University Avenue, Madison.
Van Herik, Martin	Illinois	1942	Milwaukee County Hospital, Milwaukee.
Wilhelm, Rosaline L.	Marquette	1942	209 Beaser Avenue, Ashland.

The following physicians were granted licenses through reciprocity:

Name	*School of Graduation*	*Previous Address*	*Present Address*
Broadbent, Mary	Western Reserve	Ohio	1018 North Jefferson, Milwaukee.
Cole, Alvin	Northwestern	Illinois	8122 Luella Avenue, Chicago.
Debus, Elmer	Wisconsin	Texas	2130 East Washington, Madison.
Knight, William R.	Texas	Texas	1300 University Avenue, Madison.
MacDougall, Elizabeth	Northwestern	Illinois	1205 Scott Avenue, Winnetka, Illinois.
Rodick, John C.	Tulane	Louisiana	St. Mary's Hospital, Racine.
Sagi, Joseph H.	Northwestern	Illinois	Veterans Administration, Wood.
Watts, Alice D.	Wisconsin	New York	1316 West Dayton Street, Madison.
Wynegare, David E.	Nebraska	S. Dakota	Box B, Wauwatosa.

The Wisconsin State Board of Medical Examiners, at a meeting held in Milwaukee, March 30, 31 and April 1, licensed the following physicians in the practice of medicine after they had successfully passed an examination:

Name	*School of Graduation*	*Year*	*Present Address*
Adler, Sidney J.	Wisconsin	1942	1430 West Vliet Street, Milwaukee.
Anderson, Paul D.	Marquette	1942	2027 Cass Street, La Crosse.
Belfus, Frank H.	University of Chicago	1942	2924 East Linnwood, Milwaukee.
Boerner, Herman F., Jr.	Rush	1942	3506 North Downer Avenue, Milwaukee.
Brand, William D.	Marquette	1942	2877 North 51st Street, Milwaukee.
Briggs, John N.	Northwestern	1942	5000 West Chambers, Milwaukee.
Clark, Carroll J.	Wisconsin	1942	226 North 4th Avenue, Duluth, Minnesota.
Clark, Daniel M.	Illinois	1942	Milwaukee County Hospital, Wauwatosa.
Cramer, Richard P.	Marquette	1943	1628 West Wisconsin, Milwaukee.
Currer, Paul R.	Marquette	1942	2779 North 41st Street, Milwaukee.
Dieter, Donald G.	Marquette	1943	Cobb.
French, George A.	Marquette	1943	St. Elizabeth Hospital, Appleton.
Freedman, Milton S.	Toronto	1941	Mt. Sinai Hospital, Milwaukee.
Gmeiner, James E.	Marquette	1943	Milwaukee Hospital, Wauwatosa.
Gordon, John S.	Pennsylvania	1941	950 East 59th Street, Chicago.
Haines, Brunetto J.	Marquette	1943	Arcadia.
Haman, Kenneth L.	Marquette	1943	2327 West Michigan, Milwaukee.
Hubbard, Kenneth T.	Rush	1942	2125 South 76th Street, West Allis.
Humke, Everett W.	Wisconsin	1942	2407 West State Street, Milwaukee.
Irwin, Wallace G.	Wisconsin	1942	Lodi.
Kores, Ambrose B.	Marquette	1943	Milwaukee County Hospital, Wauwatosa.
Kreher, John E.	Wisconsin	1942	Mondovi.
Lax, Aaron	Toronto	1941	Children's Hospital, Milwaukee.
Limberg, Philip W.	Wisconsin	1942	123 South Street, Plymouth.
Lohmiller, Byrlton D.	Wisconsin	1942	138 Rodney Court, Madison.
Lynch, John D.	Illinois	1942	1524 South 80th Street, Milwaukee.
Maresh, Frank	Chicago	1942	Methodist Hospital, Madison.
McNamee, James R.	Marquette	1942	603 North 89th Street, Wauwatosa.

Name	School of Graduation	Year	Present Address
Millen, Francis J.	Marquette	1943	2376 North 34th Street, Milwaukee.
Miller, George E.	Northwestern	1943	802 West 5th Street, Marshfield.
Morter, Howard V.	Marquette	1942	2934 North Stowell, Milwaukee.
Nesemann, Reynold M.	Wisconsin	1942	Algoma.
O'Meara, Mark T.	Marquette	1942	Milwaukee County Hospital, Wauwatosa.
Pfeifer, Robert H.	Northwestern	1942	New London.
Phillips, Frederick L.	Illinois	1942	5610 West Martin Drive, Milwaukee.
Pick, Daniel M.	Marquette	1943	St. Joseph's Hospital, Milwaukee.
Power, John R.	Marquette	1943	St. Joseph's Hospital, Milwaukee.
Quandt, Raymond W.	Wisconsin	1942	2200 West Kilbourn, Milwaukee.
Robinson, Thomas N.	Marquette	1943	5108 North 32nd Street, Milwaukee.
Rotter, Earle J.	Wisconsin	1942	Milwaukee.
Sanders, Reon H.	Chicago	1942	Columbia Hospital, Milwaukee.
Saxe, Jack J.	Northwestern	1943	617 West Wisconsin, Portage.
Smith, Miles B.	Wisconsin	1942	Cleveland City Hospital, Cleveland, Ohio.
Smith, Franklin R.	Marquette	1942	2826 West Kilbourn, Milwaukee.
Solberg, Marvin E.	Marquette	1943	Richland Center.
Stephanson, Earl S.	Chicago	1942	Columbia Hospital, Milwaukee.
Swanson, Robert F.	Northwestern	1942	Children's Hospital, Milwaukee.
Tomlinson, Carol F.	Wisconsin	1942	Luther Hospital, Eau Claire.
Turcott, Robert A.	Marquette	1943	Misericordia Hospital, Milwaukee.
Tweetem, Jacob K.	Wisconsin	1942	DeForest.
Twelmeyer, Henry F.	Marquette	1942	7820 Harwood, Wauwatosa.
Usow, Eugene J.	Rush	1942	2454 North 51st Street, Milwaukee.
Wells, Marvin	Wisconsin	1942	424 North Pinckney Street, Madison.
Whitrock, Robert M.	Pennsylvania	1942	Wisconsin Rapids.
Young, Charles W.	Illinois	1942	Milwaukee County Hospital, Wauwatosa.
Yunck, Robert E.	Marquette	1942	Milwaukee County Hospital, Wauwatosa.
Zantow, Forrest E.	Wisconsin	1942	1806 Chadbourne Avenue, Madison.
Ziegler, Clement T.	Marquette	1942	6301 Washington, Wauwatosa.

The following physicians were granted licenses through reciprocity:

Name	School of Graduation	Previous Address	Present Address
Pechous, Lillian A.	Loyola	Illinois	7202 3rd Avenue, Kenosha.
Stein, William	Rush	Illinois	1807 South 55th Street, Milwaukee.
Tufukuji, Mamoru	Loyola	Illinois	3026 South California Avenue, Chicago.

Society Proceedings

Douglas

Dr. Carl N. Neupert, state health officer, Madison, addressed members of the Douglas County Medical Society on August 4 at the Hotel Superior, Superior. Fourteen members attended.

Price—Taylor

On August 12, the Price–Taylor County Medical Society held a special meeting at Medford, which was called to enable its members to hear Mr. Charles H. Crownhart, Madison, secretary of the State Medical Society, discuss the proposed Farm Security Administration medical care plan. The society voted unanimously to give the plan a year's trial and appointed a Medical Service Committee composed of Dr. E. B. Elvis, Medford; Dr. H. B. Norviel, Phillips, and Dr. G. E. McKinnon, Prentice.

Trempealeau—Jackson—Buffalo

Dr. Walter P. Blount, Milwaukee, specialist in orthopedic surgery, spoke on "What Are You Doing for Backs" at a dinner meeting of the Trempealeau–Jackson–Buffalo County Medical Society at Galesville on Thursday, August 19, with twelve members in attendance.

The meeting was held in connection with an orthopedic clinic in Galesville on that day sponsored by the society with Dr. Blount as the consultant. Thirty crippled children were examined.

Waupaca

At its dinner meeting on June 22, the Waupaca County Medical Society held its annual election of officers. The following physicians were elected:

President—Dr. Herman C. Schmallenberg, New London

Secretary-Treasurer—Dr. John W. Monsted, New London

Delegate—Dr. Albert M. Christofferson, Waupaca

Alternate—Dr. James H. Murphy, Clintonville

Winnebago

The Winnebago County Medical Society held its annual stag picnic on Saturday, August 7, at Neenah. Games, entertainment, and refreshments

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provided afternoon activity. Following a 6:30 chicken dinner, a short business meeting was held.

Ninth Councilor District

The summer meeting of the Ninth Councilor District was held at Wisconsin Rapids on the evening of July 22. Preceded by a dinner at the Hotel Witter at 6:30, an exhibition of clinical cases was presented, and "The Diagnosis of Treatment of Some Tropical Diseases Which Will Be Seen in Wisconsin as the Soldiers Return" was discussed by Dr. Walter H. Jaeschke, assistant professor of clinical pathology of the State Laboratory of Hygiene, Madison, who had recently returned from New Orleans where he had been making an intensive study of tropical diseases.

Seventh Councilor District

A United States Public Health Service film on Rocky Mountain spotted fever was shown at the annual dinner meeting of the Seventh Councilor District held at the La Crosse Country Club Tuesday evening, July 20. The film showed the life cycle of the tick which transmits the disease.

Dr. B. I. Pippin, Richland Center, discussed a case of the disease which was discovered in his community and was under his care. A paper on this case written by Drs. Pippin, Richard E. Housner, and George Parke, Jr., all of the Pippin Clinic, Richland Center, appeared in the June, 1943, issue of *The Wisconsin Medical Journal.*

SOCIETY RECORDS

New Members

B. D. Lohmiller, 3604 Cross Street, Madison.
S. G. Schwarz, Humbird.
Paul D. Anderson, La Crosse.
C. J. Picard, 2231 East 5th Street, Superior.

Changes in Address

Gorton Ritchie, Racine, to 426 North Charter Street, Madison.

L. M. Cox, Chicago, to Hercules Powder Company, Plant Hospital, Baraboo.

R. C. Brown, Green Bay, to 104 North Commercial Street, Neenah.

Vernon C. Turner, Milwaukee, to 636 Church Street, Evanston, Illinois.

W. C. Keettel, Jr., Madison, to Clinton Engineer Works, Knoxville, Tennessee.

News Items and Personals

At a meeting of the Veterans Recognition Board at the State Capitol, Madison, on Friday, July 30, *Dr. Charles A. Dawson,* River Falls, a member of the Board, stated that there were about 200 discharged soldiers in the state who were mental cases and needed immediate attention. Dr. Dawson pointed out that 60 per cent of the mental cases could be rehabilitated if they received immediate treatment, and he urged immediate action by the Board to get machinery functioning to provide aid.

Another member stated that the major problem of the Board was finding available beds in hospitals for these veterans and suggested that facilities of the Civilian Conservation Corps camps now owned by the Conservation Commission could be used for those veterans who were not chronic cases and only needed rest.

Dr. Harold Coon, director of the Wisconsin Psychiatric Institute, told the Board that he could have about eight beds available at all times at the hospital for mental cases and that as soon as the Board informs him, he will make the necessary arrangements.

—△—

Dr. Harold E. Fillbach, Monroe, became affiliated on August 1, 1943, with two other Monroe physicians, *Dr. Clarence E. Baumle* and *Lieutenant David D. Ruehlman.* Dr. Fillbach, a 1922 graduate of the Northwestern University School of Medicine, will remain in the Ruehlman and Baumle office during the absence of Lieutenant Ruehlman, who reported for active duty with the armed services of the United States on August 9.

For eighteen years, Dr. Fillbach had his own hospital at Hazel Green but sold it in 1941 and went to Cuba City to practice. He began his practice in Monroe, March 1, 1942.

—△—

Dr. Gorton Ritchie, formerly of Racine, pathologist who took his undergraduate work at the University of Wisconsin, has returned to the University to serve on the staff of the Medical School.

—△—

Dr. Fred J. Pfeifer, New London, was guest speaker Thursday evening, August 5, at the regular monthly meeting of the Lutheran Men's Club, New London. The subject of his talk was "Who's Crazy?"

—△—

Dr. Arnold S. Jackson of the Jackson Clinic, Madison, announces the addition of the Department of Allergy and the Department of Pediatrics to the Clinic on July 1. Dr. Beatrice Payne Knight is in charge of the Department of Allergy, and Dr. Margaret Prouty, the Department of Pediatrics. Both physicians are new to the staff of the Clinic.

—△—

Dr. Gwilym Davies, Waukesha, was a guest lecturer before the class in tropical medicine at the Marquette University School of Medicine on August 20. His subject was "Tropical Medical Practice in Africa." Dr. Davies was a medical missionary in equatorial Africa for many years.

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BIRTHS

A daughter, Jean Evelyn, to Dr. and Mrs. Christopher R. Dix, Milwaukee, on July 19.

MARRIAGES

Dr. Anthony J. Frederick, Columbus, and Roshara Bussewitz, Horicon, on August 21 at Horicon.

DEATHS

Dr. William H. Finney, 68, Clintonville, died Sunday, July 25, five days after he had undergone an emergency operation for appendicitis. Born in Clintonville July 14, 1875, he was the son of the late Dr. and Mrs. John Finney, pioneer residents of the community.

He attended the University of Pennsylvania and received his degree in medicine from the Northwestern University Medical School, Chicago, in 1899, after which he immediately established a practice in his home town. For forty-three years he was a physician and surgeon for the Chicago and North Western Railway Company.

During World War I, he served at Camp Dodge, Iowa, and at Fort Riley, Kansas, in the medical corps. During the latter assignment, he distinguished himself for his work in the influenza epidemic.

He was a member of the Waupaca County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

His only survivor is his widow.

Dr. Siegfried Kraft, 60, a physician and surgeon at the Sheboygan Clinic, Sheboygan, for the last twenty-one years, died at Rochester, Minnesota, on Tuesday, August 3. He had submitted to an operation on July 26.

Dr. Kraft came to the United States and to Sheboygan directly from Germany, where he was a professor in a German university. He was graduated in 1909 from the Leopold Franzens University Faculty of Medicine, Innsbruck.

He was a member of the Sheboygan County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors are his widow and two daughters.

Dr. William R. Kennedy, 71, eye, ear, nose and throat specialist in Milwaukee for forty years, died Tuesday, August 3, following an illness of five months.

A native of Missouri, he was graduated from the State University of Iowa College of Homeopathic Medicine, Iowa City, in 1895 and later took postgraduate work at the University of Edinburgh in Scotland and at Rush Medical College, Chicago. At one time he was an instructor at Marquette University, Milwaukee.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow, three daughters and two brothers.

THE PRESS

"Oh Doctor, Doctor"

"When your tummie aches and you're full of pain and you call the doctor again and again and he finally comes to put you at ease; taps you gently from chest to knees and finds the spot where it hurts like h____ and you say 'Oh, Doctor, Doctor, will I ever get well,' and he knits his brow, then cracks a smile and says 'Of course you will in a little while, but you've got to stop filling your tummie so full, you're eating as much as a Holstein bull.'

"And when you know you're not going to die after eating a great big blueberry pie and the ache goes away and back comes your health and you say 'Oh, Doctor, Doctor, health sure is wealth,' then you begin to appreciate in a modest way, the cares of a doctor day after day. You're only one of the public at large whose health he's guarding—it's a nation wide charge.

"Pushing my way into a booth at Alma Friberg's cafe the other noon I visited about three minutes with Dr. R. G. Arveson of the Frederic Clinic. He was impatient to get through lunch. I lectured to him briefly about slipping into second speed now and then. 'There's too much to do, too many sick people who need help. I've got to keep going.' I noticed to the right of the doctor's coffee a stack of official looking papers, on top of which rested a beautiful Parker desk pen set done in black onyx trimmed with gold on a hand engraved plate.

" 'Are you so busy, doctor, you have to carry your mail with you and desk set (pen and ink) for your signature while lunching?' I inquired. Modestly he turned the desk set toward me and I read the following:

" 'Presented by the State Medical Society of Wisconsin May 17, 1943, to R. G. Arveson, M. D., Frederic, Wisconsin, "Father" of the Wisconsin Law for the Annual Registration of Physicians. This pen was used by Governor Walter S. Goodland in signing the act, Chapter 155.'

"The desk set had just arrived. I think Mrs. Arveson had brought it to him as a surprise. Who wouldn't feel happy and glow a bit after years of public service to be called 'FATHER' of a law designed to protect you and me from becoming victims of quacks, incompetents and charlatans. From now on all physicians in the State of Wisconsin must register each year. The law sets up a kind of

inventory, WHO'S WHO, for publication by the State Medical Society. Every law enforcement officer will know who is licensed to practice and is practicing in the state.

"The law, for the first time, will provide the State Board of Medical Examiners with enough money to enforce the Medical Practice Act, which means better health insurance for you and me. In addition, the inventory each year will be of immeasurable value in assisting in the proper distribution of doctors at the end of the war.

"A similar law has proven highly satisfactory as a public health measure in twenty-three other states where it is now in force. Take a bow, Frederic.

"Recently in Pennsylvania, agents found a so-called doctor making easy money selling blood pressure pills to about to be draftees, guaranteed to raise blood pressure, so when examined, Army doctors would reject them. Laws like Dr. Arveson's are protective measures." From "Ridin' Herd with an Old Cow Hand—Cap'n Flagg" in *The Frederic Star*, August 5, 1943.

Medical Science Able to Show Concrete Results

"An army equal to the number of men drafted during 1917 and 1918 and more than twice as large as the American forces that fought in France during the last war is the contribution to victory made by public health activities and medical science in the United States.

"The steadily decreasing death rate of the last forty years, or since the turn of the century, means that we have available for the assembly line and for combat 2,800,000 male persons who would not have been available had the mortality rate of 1,900 continued to the present time.

"Organized public health effort to prevent and check disease, to improve diet and sanitary conditions and build bodily resistance can be given credit for this tremendous saving of life. The immunization program, child health conferences, and visits of public health nurses to our homes are among the activities that helped to insure victory long before the war began!

"To measure what this work means in man power, a comparison has been made between the death rate in 1900 and the death rate for the years since that time. The result shows that at least 11 per cent of men between 20 and 44 years of age are with us now because you and your neighbor have been working together to better the health conditions in school and community.

"Even this figure is modest because it fails to consider that if the mortality of 1,900 had continued to exist, many persons who are now parents of men of draft age would have died before attaining parenthood.

"If keeping well was important during peace, it is twice as important now because there are two goals to achieve: early victory and lasting peace. 'Business as usual' may be out for the duration, but public health work must go on as usual even if it means more effort." From the *Berlin Journal*, July 29, 1943.

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One-Man Medical System

"A bill recently introduced in the senate to radically broaden social security legislation would, among other things, set up a socialized medical system that would ultimately destroy the independence of medical men, the present high standards of the medical profession, together with a medical system which has added more in a few decades to the health of the human race than centuries of medical development in Europe.

"The new system that is proposed would place in the hands of one man, the Surgeon General of the Public Health Service, the responsibility of administering free of charge to the medical needs of more than one hundred and ten million people. He would have at his disposal, to be used as his judgment dictated, approximately $3,000,000,000 to be collected annually from the taxpayers.

"It is estimated that, at the present time, there are in the United States, available for civilian practice, 120,000 effective physicians. With $3,000,000,000, the surgeon general could, after allocating 20 per cent for administration costs, hire every physician in the United States at an average salary of $5,000 a year; buy every available bed in every non-government-owned hospital 365 days each year at $5 per day; pay $2.50 per day for each and every government-owned hospital bed 365 days in the year, and still have left for drugs and medicines $168,565,887.50.

"It does not seem possible that free American citizens want a one-man medical system any more than they want a one-man government." From the *Westby Times*, August 4, 1943.

Shortage of Doctors

"We can get along somehow when the cobbler leaves town and we need new soles for our shoes. The printer is not indispensible because we can send away for our stationery. But stricken is the community that loses its one and only doctor.

"The war is causing a steady drain on the man power of every community. The army has need for the skills of every man and especially of the physician. And so we find that where big factories had in their employ doctors or at least internes, these have been taken up by the government and trained nurses have replaced them.

"We have here locally a case illustrating the shortage of doctors in the present position of the Oak sanatorium. It had until recently a full time physician. It has been charged that some of the patients have demanded a replacement of such service rather than the part time services of a doctor and a registered nurse in charge. While we believe that the modern treatment of tuberculosis would suggest this, the present setup appears to have been accepted by the patients and it is similar to arrangements to be found in most of the small county institutions. It is not a case of being entirely dissatisfied with the present arrangement of a consulting and part time service supplied now. There is nothing to indicate the incapability of such. It is just that present conditions make for a shortage of doctors and the fuller medical attention available in normal times. If patients were to be transferred to the state sanatorium it would but help over-burden the staff there.

"There is no doubt but that two or three large sanatoria in the state in place of the present twenty-two would offer advantages. There could be a larger staff of physicians especially trained in tuberculosis work stationed at each as well as better facilities including operating and laboratory departments. A rehabilitation program with the necessary equipment could better be supplied. But at the same time we realize the regard that some patients have for small sanatoria with their more home-like atmosphere and their proximity to the patients' home neighborhood.

"A few days ago we picked up a man at Goerke's Corners who was hitchhiking in the direction of Madison. Maybe being a little indiscreet we asked if he sought work there or if that was him home town. No, he said, he was going there to solicit funds for a school of the blind in Milwaukee. We suspected then that he too might be blind or at least partially so, but said nothing of course. He pointed to the rear view mirror and said that people had come to take such small things for granted. We agreed and suggested that even large things such as radios were little appreciated anymore from the angle of marveling at their invention. The conversation drifted to such things then as automobiles and aeroplanes and about that time we were passing the county airport but our companion did not notice about six planes out on the field. The sun shade on the passenger side of our car has a tendency to fall down occasionally and it did so several

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times during our drive but our companion seemingly did not notice this obstruction of vision. So we point to this as an example of how people should face misfortune in being handicapped or when faced with illness. Less complaining makes the whole world feel better off.

"Those nurses, waitresses, janitors and other help needed to run our institutions are to be recommended for staying at their jobs these days when there is such a demand for labor at higher wages in the war production factories. The state has tried to help by increasing salaries but they still do not compare with those paid in private industry.

"The best advice that we can offer now is that people do not get sick for the duration." From the *Pewaukee Lake Diary*, July 8, 1943.

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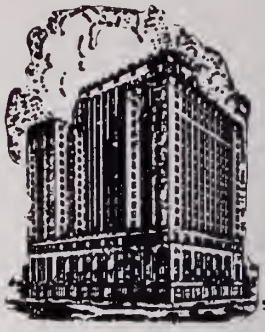

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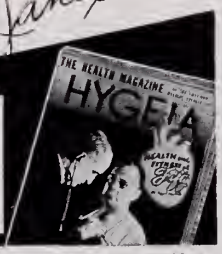

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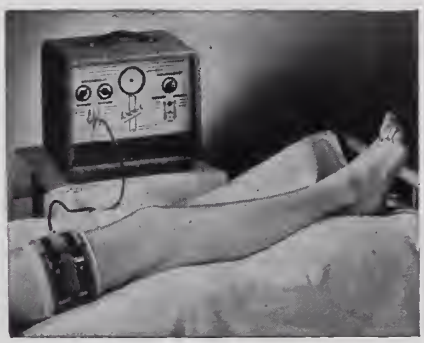

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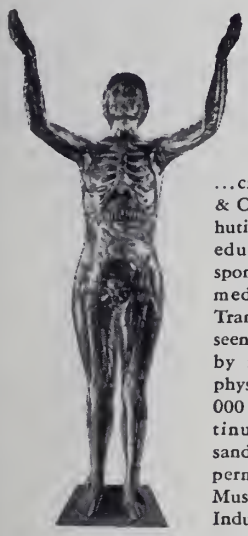

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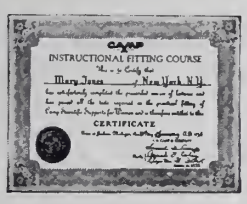

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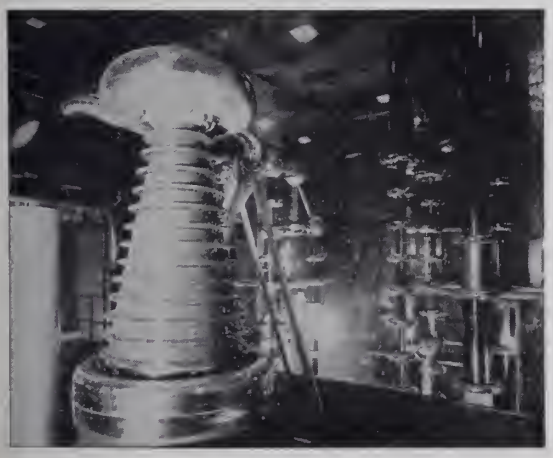

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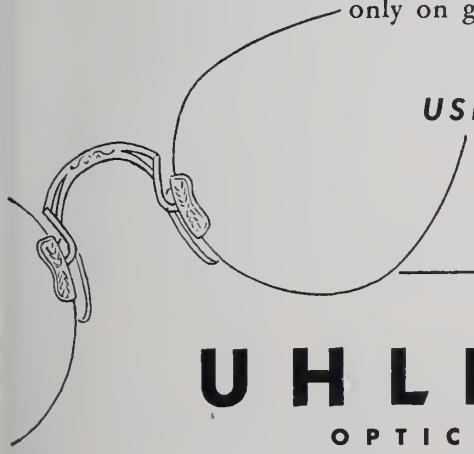

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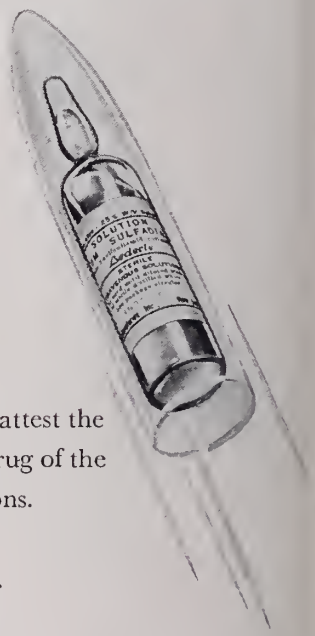

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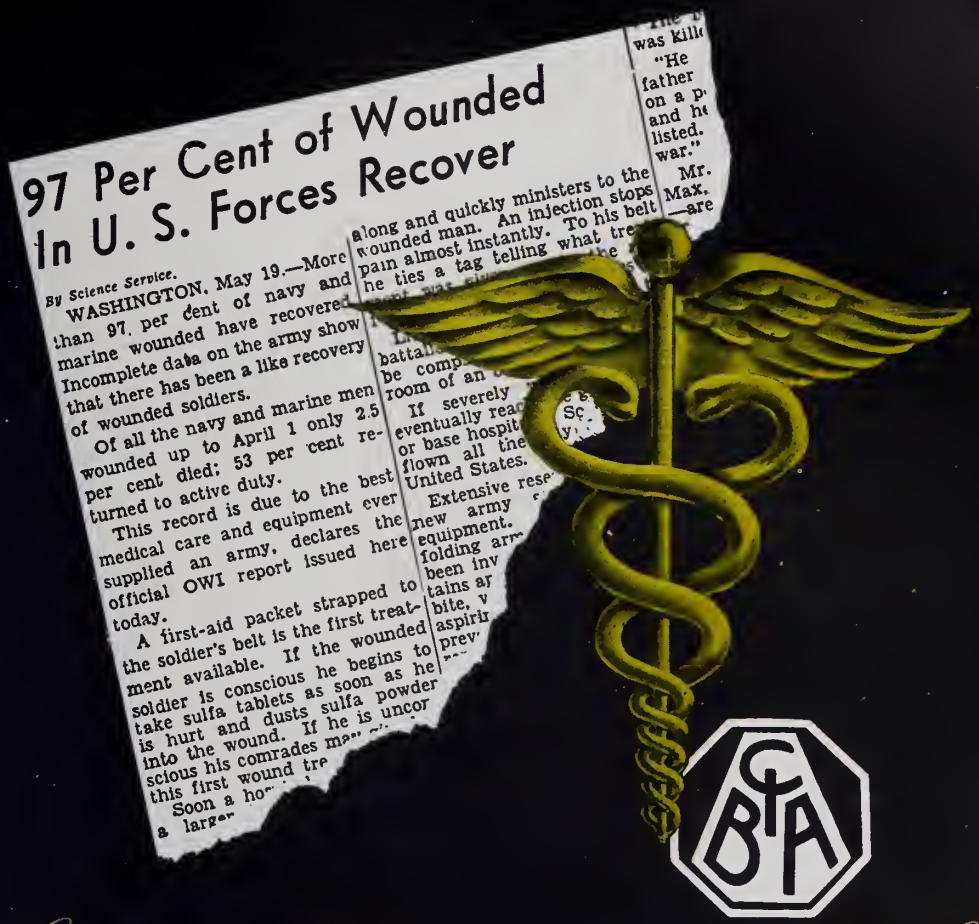

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THE WISCONSIN MEDICAL JOURNAL

VOLUME 42, NO. 10 Copyright, 1943, by The State Medical Society of Wisconsin OCTOBER, 1943

The Pattern*

By RUSSELL M. KURTEN, M. D.
Racine

R. M. KURTEN

Dr. Kurten is president of the State Medical Society of Wisconsin.

EACH year it becomes the privilege of the president of your society to address the general assembly, and I am grateful for the opporunity of reporting on my stewardship. For the last six months I have acted as your president due to the untimely death of that grand exponent of medical practice and sound medical economics, Dr. Frank Butler, who passed away in March of this year.

Secretarial Staff

In reporting to this assembly, I would be remiss in my duty if I did not refer to the excellence of the organization's staff, expertly directed by our secretary, Charlie Crownhart, and his able assistant, George Larson. Their efficiency in matters of organization has been attested to this year on numerous occasions. I call your especial attention to the industrial health meetings and to the splendid job they have done in furnishing the legislature with factual data and guidance on medical matters, which is reflected by our legislative experience in this year's session when we not only had matters adverse to the public's best interest killed but new legislation introduced and passed, which has greatly strengthened the citadel of public health and welfare in this state.

Dr. C. A. Dawson

No mean proportion of this latter success is due to the Committee on Public Policy headed by Dr. C. A. Dawson of River Falls. Dr. Dawson has given lavishly of his time in the analysis of legislation, and through his intimate knowledge of men and affairs at the Capitol, he has been an influence for which you and the citizenry of Wisconsin owe him a lasting debt.

Council on Scientific Work

To the Council on Scientific Work I extend my heartiest congratulations for a program of great merit. Its work covers every phase of scientific activity in this Society's comprehensive program. Since its members are appointed for five-year terms, the extent of their contribution to you and your Society can be visualized.

The Committees

I offer my gratitude to all of you who have worked on committees during the year. It is your activities that make this Society an outstanding one. Those appointed to this work are, of course, directly responsible and should take the initiative, explore the field thoroughly, gather all facts obtainable, meet as often as is necessary, and go ahead without directional guidance from the secretary's office, once they are acquainted with their assignment, since that office is too busy to do more than counsel them. A committee assignment may lead to an entirely new avenue of activity which may be of tremen-

* Presidential address presented at the One Hundred Second Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1943.

dous value to the organization in its determination to serve public health in the fullest measure. Those of you not on a committee can consider yourselves ex-officio on any and all, and your advice and help will be appreciated by any committee or the Council. A suggestion to our secretary of your interest will bring you an invitation to participate.

Dr. Robert Fitzgerald

May I take this opportunity to pay tribute to my friend, Robert Fitzgerald, for the magnificent contribution he has made to the war effort and your Society's effectiveness in handling the Procurement and Assignment Service? This colossal job done in the face of constantly changing and often contradictory directives, plus the conflicting interests of physicians in the program, made it a difficult assignment. Bob has done it well, and I wish to thank him publicly for the tremendous personal sacrifice he has made.

The Council

I must, while in this lauditory mood, express my sincere thanks and gratitude to the Council of the State Medical Society, which has given unstintingly of its time and knowledge of medicosocial economics enabling this Society to maintain its position among the leaders on the national level. As you know, the Council members are elected by the House of Delegates for three year terms. Each reflects the excellence of judgment by that body in choosing men from your respective districts to act on your board of directors which carries on the Society's business during the interim between annual sessions. Only an alert, interested Council could have guided so expertly your ship of state through the troubled waters of the last few years.

The House of Delegates

This brings us to the county level, because it is from that level the delegates to the House originate. The type of man sent us each year to help plot the course of the ensuing year, as is done at each annual session of the House of Delegates, reflects the interest and concern you members have in the destiny of your profession and its obligation to maintain the highest standard of medical care to the most enlightened and discriminating citizenry in the world. Select men, therefore, who have demonstrated their interest in the organization's activities.

The American Medical Association

I desire to discuss at some length the organization responsible for, and to, medicine in this country, the American Medical Association. To many of you, the American Medical Association is the organization that publishes weekly the journal accumulating on your desk, to be read regularly by some, occasionally by others. Some of you read only its scientific sections, others "Tonics and Sedatives," and others all, including that very important section on organization. I wish for the moment to stress the latter section because only by reviewing constantly the material published there can you keep abreast of your Association's position and views in the rapidly changing socioeconomic environment in which you practice your art. This should, of course, be supplemented by material appearing regularly in the lay press and periodicals leveled at the public which both acclaim and defame our profession. It is well to be informed on a 360 degree horizon where our profession is concerned if we would keep ahead of the public's interest.

I have digressed from my purpose, which is not to become pedagogic and tell you what you must and must not read and how to spend your leisure hours of which you have had all too few in recent months; rather, I desire to set before you the pattern of medical organization in this country. I am sure too few of you give any thought to the fundamentals of its democratic structure and the dependence it has on you as individuals to be efficient and representative of medical thought and action.

It is conceded that many of the problems confronting us in medical economics are the direct result of failure on the part of individuals and groups of practitioners, through the last two or three decades, to conform to the principles laid down by the American Medical Association. Chickens are coming home to roost. If you have ideas or are being tempted by some revolutionary ones,

avail yourselves of the experience that your organization has on the county, state, and national level before making a commitment. If you are right, you will be strengthened; if wrong, you and medicine in general will be protected. If there is no experience or precedent, you can rest assured the resources of the Association will be made available to establish a course. It may take time, but so has scientific medical progress. No group or movement will suffer in the meanwhile, because our system has made American medicine and public health pre-eminent.

Organization Structure

The organization structure is a simple, democratic one, under direct control of us members of component county societies. The executive branch consists of a president elected yearly, a year in advance of assuming office, a treasurer, secretary, and speaker and vice-speaker of the House of Delegates. The identical pattern we have at the state level.

Its legislative arm and the only policy-making body is the House of Delegates, which group convenes annually at the annual meeting. Its membership is composed of men duly elected by the houses of delegates of the component state societies, each state being allotted delegates in proportion to the membership roll. This makes for a pattern of representation from urban, rural, industrial, agrarian, economically substantial, economically low grade areas and, in the aggregate, a surprisingly well balanced body objectively and subjectively. It brings together sharp minds schooled in medical science and, in addition, well versed in medical economics, as well as ordinary minds that see things through the eyes of the humble public, served by us on a many thousand-to-one ratio. It also brings together progressive minds and conservative minds, reactionaries and those cemented to the past, some who want the name but not the game and who are interested only in being among the great and near great. It is a cross section of genus Americana. The representation and machinery for action is there, if leadership is supplied. This has lagged at times in the past for several decades.

Board of Directors

The Board of Directors, analogous to our Council, is elected by the House, and its members are always men with a background of scientific accomplishment and schooled through years of active participation in the lore of medical socioeconomics. They manage the numerous publishing activities of the Association and direct the numerous councils and bureaus such as those dealing with medical education, drugs, equipment, scientific assembly, and so forth, in all, some thirteen or fourteen, each devoted to a specialized and highly important angle of medical service. They must, of course, be kept atuned to all levels in the Association and in society, must accommodate themselves to the realities of social change, and modify their course as it becomes their obligation, as leaders and statesmen.

Public Relations

The secretary and general manager, Dr. Olin West, an incumbent of many years, is elected annually and has a legion of duties not the least important of which is public relations. It would appear that the Association's able editor has assumed that most important function in the minds of the public, the press, and most doctors of medicine, not entirely to the latter's acceptance and approval. Rest assured, however, that little will be represented to the public or press that has not been considered and blessed by a pontifically demeanored Board of Directors. The fact remains that our public relations are not all that could be desired. It is hoped that the recently appointed Council on Medical Service and Public Relations will change this for the better.

All other executives and personnel are employees and answerable to the Board of Directors. The structure is sound; its functions require adaptation to the present and future. You activate function by your interest and concern. If you remain passive in these momentous times, don't criticize the House of Delegates, the Board, or the officers. Remember, the torch is yours to carry forward and keep aflame. Personnel can be changed in our own circle; principles and patterns established come in the public's do-

main and are difficult to alter and often frustrate future developments. Your activity in the state Society will register in the national body.

Our Association a Democratic One

My thesis is that organized medicine is the force behind medical progress but must be kept labile and contemporary. I quote from Thomas Paine's "Rights of Man": "Every age and generation must be as free to act for itself, in all cases, as the ages and generations which preceded it, The vanity, of presumption of governing beyond the grave, is the most ridiculous and insolent of all tyrannies. Laws made in a previous generation and continued into succeeding generations derive force from the consent of the living. They remain in force because they are not repealed. Non-repeal is evidence of contemporary consent. This implies a grave obligation to keep in review, changing pattern." It is my contention that our Association is a democratic one, governed by persons of our own choice and established according to accepted principles of the legitimacy of government. Through an elective and democratic principle of power, our organization establishes its position to speak for medicine in this country. All ethical physicians can participate, and all are eligible to vote on the level of the county and, through their delegates, on the state and national levels. They can be heard at any level. Its legitimacy is a justification of power. Of all human iniquities and inequalities none is as important in its effects or has greater need of logical justification as that established by power. Jean Jacques Rousseau conceived the fundamental premise of democracy, "that man is naturally good." It is this thought that permiates American thinking to such a remarkable degree that our American institutions reflect generally this concept. Faith in the natural goodness of man is necessary to any democratic process. Authentic power is based on the presumption that a good and right decision will naturally sway more men than a bad or wrong one. A decision of the majority may not be right in the absolute but is made legitimate by the fact that the majority adopted it.

As far as medicine is concerned, if the foregoing thesis is correct, we can assume, despite cries to the contrary and Supreme Court decisions notwithstanding, that the American Medical Association speaks for medicine and that the principles laid down by its governing body are those of the majority of the physicians of this country. When there is major disagreement on principle, our democratic machinery is equal to the task of modifying or completely changing it. That, gentlemen, is our obligation and debt to medicine and the public at large. Therefore, your familiarity with this entire structure is obligatory if our institutions are to remain as evidence of contemporary consent, as evidence of the force of the living and not, as certain social reformers would testify, the voice of an archaic past. Your interest and cooperation are necessary to keep it a force.

Your Obligation to Preserve the Ideals of Medicine

Government is always an organized minority that has to do with isolated individuals or groups. The strongest government would fall in a few hours, police and courts would be completely and instantaneously paralyzed if all the governed came simultaneously to an agreement to withhold obedience. It is so with medicine and the ethical and moral concepts of its organization, as they relate to professional and interprofessional rights and privileges and in medicine's relationship to the public at large. You as individuals should be prepared to protect the good name and aims of the state Society and the national Association and to follow their edicts. You have the further obligation to preserve their institutions and policies for those more than 60,000 of our colleagues temporarily removed from the scene by the exigencies of war and to bring into being such sound policies as are consistent with their ideals of practice. Their ideals may be modified by some years of mass practice on what might be considered a semi-socialized level.

We have also to meet the challenge of that group which, both through recognized representation in government and by being self

appointed, have by usage gained public leadership in social thought. These forces will surely be militant on the cessation of hostilities to achieve their concept of social gain. Much that accrues from this group and its activities is due to lack of leadership in contradisciplines. We too often fail to keep a pace of reactionary forces, and when much momentum is attained by such forces, ours is too late and too weak. Being aware of medical disciplines and the principles that keep our state and national organizations in power, namely, public acceptance and professional acceptance based on wise and cautious leadership, gives us the opportunity to set up a bulwark of forces to keep medicine on the highest plane of service in the interest of public health and yet preserve for its practitioners a position making for a strong and enterprising profession, living up to the best traditions of professional dignity and integrity.

What is the origin and genesis of some of the social bombs leveled at us as physicians and at our association, which sets high standards for the training of its neophytes, the ethical practice of the healing art, the rapid and precise promulgation of scientific discovery and knowledge, and also our contact with political and economic agencies? Many of these charges date back to the beginning of medical practice on a scientific basis and are apparitions of cultists, pragmatists, religious, social and pseudoscientific organizations, dressed and garnished in the mode of each succeeding era. Through their lack of probity, succeeding proponents of neo-Utopian ideologies pyramid the defamations. These are only tantalizing forays against our bastions, however, and are of interest because they encourage cults whose predatory methods are dangerous to public health.

The Profession Has Been Smug

There is a background for contentious thought on the delivery of medical care and a trail back to its origin. Each major conflict on the battlefield and in government reform has resulted in major alteration of social thought and patterns. Medicine has of course participated in the mutation. An awareness of this situation has escaped many practitioners, smug behind the protection of a license and a powerful organization which could dictate how and in what institution a man could practice, public acceptance of medical service as delivered, no real competition except his fellow practitioners, no ceiling on his fees except his own conscience, no limit on the work he could do except his courage and stamina. A growing tendency toward acquisitiveness by practitioners and a disregard of the old tradition of physician-patient relationship, which brought people to their doctor in all difficulties for advice and consolation, destroyed much in good public relations and rendered us individually vulnerable.

The lower income group was getting medical attention but not medical service in its broad sense. This and other factors precipitated social action. Social workers maintaining that while the content of medicine is in the profession's domain, the circumstances under which it is practiced and the economic relation to society or the individual patient are problems of organization in the public domain, in which physicians are only one among many who are vitally interested.

It is further maintained that society determines who may hold himself out as a physician, and in return for this exclusive licensure, extracts from him the price of his professional code which requires service to all without regard for ability to pay. Since society accepts broad responsibility for dependency and destitution, it must also make adequate provisions for health service. With the high type of medical service available, inadequacies of distribution are a luxury the country cannot afford.

We Chose the Negative Approach

Lack of medical leadership has permitted medicine to escape reality. Poor sailors, we did not recognize, much less heed, the evidences of a storm brewing and set our sails accordingly. We chose the negative approach to oppose or disregard until the Supreme Court destroyed sufficient of our leverage to make our organization vulnerable.

Those of you who read General Rankin's and Dr. Paullin's talks given at the annual meeting of the House of Delegates in Chicago early in June will recognize that medicine is departing from that smugness of persons sacrosanct and immune to changing patterns and is becoming realistic. I would be presumptuous beyond the dignity of the office which I hold in your Society were I to venture a plan or program for our Armageddon, but I ask you to differentiate between what is political balderdash and pseudoeconomics and what is planned social progress conceived generations ago for the betterment and security of the common man and in which medicine has been the greatest influence. Medicine's interest lies with the common man by tradition and desire; it only wants to be sure. Remember that social change does not come on any appreciable scale except as it represents a common interest of the majority and does not originate at the point of production. In other words, all social legislation is the result of a struggle for security by the people in their humble surroundings, being sensed only when it has gained cumulative force and public opinion becomes amplified to such a pitch that even politicians can no longer ignore it and the press no longer dampen it. Therefore, whatever departure from the present form of delivery of medical care is developed as part of the postwar economy, it will have the blessing of the multitudes in theory. The practice will be imperfect but one can definitely state perfectable. The insurance principle cannot be gainsaid and will be a basis for any program. The sacred principles of medicine, service to all, with ethical relationship between doctor and patient, no interference with research and the dissemination of the products, the right to select who shall be treated and how, according to medical concepts not social edicts, must be preserved. The retention of the principle of individual initiative, enterprise, and skill, as the motivating force for advancement and recognition, must be preserved in the public's interest. Our selfish interests per se will carry little weight in this struggle.

A Bureau of Health

Practitioners of medicine will have to be conditioned to this change in attitude, after having been trained to oppose change and to term as reactionary devices set up by what was called a radical program. True, the Beveridge Plan for England and similar ones in Canada, Australia and New Zealand, all English speaking nations, have cushioned the reversal, but politicians, and those who would delude us to escape responsibility, will still insist on a political genesis rather than a social reform growing out of public demand. The fact that five states already have going plans for prepaid medical service, two of which were forced into it to escape legislative creation of a plan, can be argued either way, depending on the point of view. We are likely to be misled by semantics and symbolism which have become the going philosophy of political mountebanks and short-sighted business and professional men who can see great social evil in public servants with Terpsichorean proclivities, reading *The Nation* or *New Republic*, or holding any brief for the common man in his struggle for security. So gullible and passive have we become that because of such words as Anglophiles, radicals, dictator complex, war monger, communist, America First, collaborationist, and so forth, a few myopic congressmen could nearly scuttle our preparedness for war. Paralleling this undemocratic and banal activity is the considering of every action of an opposing party or political school of thought as the offshoot of bureaucracy. A bureau is a thoroughly approved device for conducting research and handling details in government and every type of business or professional activity with which I am acquainted. It is an especially important means of avoiding political interference and bringing about factual data unflavored by political corruption and patronage. Facts, of course, do worry politicians who are not statesmen. We as physicians would like to develop a department or bureau of health, and rightfully so. If the system of bureaus is too cumbersome by virtue of over expansion, that is something to consider and correct, but if precedent is a

criterion, I will wager a change of administration will not modify it essentially. In my opinion, its present free use is merely a scapegoat to avoid responsibility and the task of leadership. Whenever an explanation of defects or failure to accomplish is demanded of politicians of the modern mold, bureaucracy is the escape foisted.

To beat legislative action, either state, federal or both, to the punch surely cannot justify the position of medicine today, which has suddenly sensed a ground swell that has been gaining momentum ever since the last war and is now so obvious that even the most confirmed conservatives are being stampeded into doing something quickly to meet the demand for prepaid medical service in the lower income brackets.

A Crying Need for Gifted Statesmen in Medicine

Statesmanship is that particular quality which demonstrates unusual wisdom in treating or directing great public matters, and a statesman is a man actually occupied with the affairs of government or a cause and influential in shaping its policy. Now as never before, albeit belatedly, there is a crying need for such gifted persons on the county, state, and national level of medical organization. Through it medicine, in its intrenched position of pre-eminence by virtue of accomplishment in the health field, a personnel trained second to none in the world, and a well implemented system of training those desiring to enter its field, can write the terms for its future delivery and extricate itself from a disastrous position. However, it will require statesmanship of the Churchill not of the Chamberlin type.

We in Wisconsin and our sister state Minnesota have demonstrated the practicability of an educational legislative bureau by the acceptance of our tenets by enlightened legislatures. The same crusade in every state and on the national level will hold the forces of progress to orderly procedures of rectification. No power we possess will, as has been our attempt, hold back the dawn. We should recognize the economic necessities demonstrated to exist and their trend and work out a system for delivery of medical care that will meet the contingency.

I am not certain that present schemes will be to medicine's or the public's best interest in escaping our dilemma. We should not, I feel, give up the fundamentals of our form of practice, namely, a just fee for service, the recognition of superior training and ability and its financial reward, the responsibility of medicine to decide how a person will be treated without answering to an agency or suffering a penalty for intelligently grouped multiple procedures, as becomes a pattern with certain plans already a reality and in the making.

Security Protected on a Voluntary Basis

I believe any system developed should recognize an individual's responsibility to meet contingencies and expect only substantial aid through the insurance principle. I shudder for a civilization reared on collective security. Each responsibility of the family group accepted by another agency invites greater dependence and becomes a stone in the arch of this ideology. The theory of thrift and dependence on one's own competency to meet bodily needs cannot be suddenly subjugated for the public by government or medicine without penalty to our people. We can, however, make available means of protecting their security on a voluntary basis through insurance to assist in catastrophic illness on a cash indemnity basis paid directly to the insured. We should not look at such service as a fee-collecting agency. Medicine, by establishing a minimum fee schedule in each locality and exercising its prerogative to see that the public is not exploited because of a subsidy being available, will in effect give the public what it demands and yet permit physicians to adapt fees to graded procedures in individual brackets of procedure. The financial status of the patient, plus operative description and laboratory findings, establishes the validity of a claim in the event of controversy. Conscientious physicians will recognize their responsibility to society and their profession and mark such a plan feasible.

We can further expand the potential resources in knowledge and practice for the prevention of disease and improving nutrition and mental hygiene. Much can be done

in farm and industrial health and hygiene to defer senescence, cut down accident rates, minimize permanent disabilities, make possible shorter hours and greater recreational facilities to the end of cutting down the cost of medical care.

Industry's Obligation

Industry and commerce too have an important obligation to society to stabilize incomes and cease exploitation of labor and the farmer. The security brought about by a social consciousness in commerce and industry would do much to reduce the type of medicine mostly psychosomatic, which is so costly and difficult to handle. It would do much to correct what evils still exist in organized labor. It would obviate, in the form of benevolent associations and partially subsidized insurance schemes utilizing private group practice, methods to attempt to cover excessive profits and lower wages. Our war economy will be gone with the wind, and, in a peace time economy, a dollar will be of consequence. The war economy tax load will go on for years to come.

The matter of nutrition on a national level has not reached beyond vitamin exploitation in the average home. Heating, cooling, and ventilation, important factors in health, are just beginning to be recognized as subjects in our domain. Housing and sanitation leave much to be desired in many parts of our country, urban and rural. Yet they are important components of a medical and health plan for society in general.

If I can interpret the National Resources Planning Board blue print for security, that approach is favored over state or federal medicine. The Wagner bill is, of course, a more direct threat and must be reckoned with soon.

Orientation at the County Level

It is emphasized that orientation at the county level must be accomplished if the future program is to be representative of American medicine. True, we can fall in line and accept whatever is elaborated, but failure of acceptance in principle and fact by practitioners will make for a de facto situation and undermine the force and influence of the organization of medicine. A statesman-like aproach will require a complete exposé of the picture and a survey of local requirement, plus a job of salesmanship on factual premises. There should be such data coming to you from the state Society and the American Medical Association to aid the study. Facts learned should be passed on. Such an interchange of ideas and realities will be worthy of our cause. I cannot gracefully accept complete surrender to a bogey even though couched in saving phrases and mechanics.

The Hospital Problem

It is further to be emphasized that caring for the lower income group of patients is only a part of the problem. There is the growing tendency toward centralization. Unless a stand is taken postwar medicine will be centered about the hospital, and we practitioners will be merely their tools in the health program. A most difficult problem in medicine has been the establishment of privilege to do specific work. Organized medicine has totally ignored it and accepted the license as a blanket privilege. Hospitals have been aware of it, but staff organization, except in large, closely knit hospitals, have frustrated progress. We recognize the necessity of specialization and advance training. When will we take official steps to assist hospital staffs and boards to utilize the fundamental principles? I believe it would strengthen medicine's position and weaken the hospital's in the struggle for control of practice. The reality could not come about suddenly, but an expression of principle would do much, and eventually graded licenses could make the status official. That these are broad implications I am aware, but they are nothing that statesmanship and honesty of purpose could not justify and solve.

As has been emphasized earlier, a physician is a vital force in his community. He has since the beginning been well educated, a practical humanist, an individualist, and a scientist. He has the respect and confidence

of his patients and the public generally, if he deports himself as a true physician. Collectively we have the ear of 99.9 per cent of the public as intimately as do clergymen. This potential force used in the public weal would be irresistable. Moral and political forces appreciate this. A wise leadership could make it serve the public well.

Your Part

What can you as individuals and through your county societies do to restore the force and influence of the physician in public affairs and bring the potential force of medicine to bear on legislators and policy-making social groups?

1. You must first be alert to medical progress and practice, good medicine on the most economical and ethical scale possible, not cheap medicine but medicine based on a carefully arrived at diagnosis and without therapeutic frills.

2. You must maintain an interest in your patients beyond scientific medicine in order to invite their friendship and trust in you so that you may assume that legendary place of father confessor and guide in social and economic problems. Such an interest made medicine strong and successful before medicine became a science and will be a bulwark now in its economic crisis.

3. Interest yourselves in civic affairs. Be active in clean politics, education and cultural developments. You are all educated men capable of paying a debt to society for the privilege of licensure and respect for the sacred traditions of medicine. Support financially and viva voce all worthy civic causes, always with restraint and dignity as becomes a professional man.

Carry this interest in public affairs to your county society. Have that body take its rightful place as arbiters of all matters in the medical field, public health, and institutional care. Encourage strong hospital staffs which make for well equipped, smooth functioning hospitals for the public's protection. Encourage specialization for involved fields, but give general practitioners all the encouragement and assistance to keep the plane of their practice high and broad.

Be loyal to medical ethics and the sacred principles of organized medicine. Keep your ear to the ground when a movement seems to be gaining credence and momentum. Bring it to your local society and up to the state level. Do not engage in any form of practice looked upon with disfavor by your local, state, and national societies. Keep medical practice a medical function by avoiding deals and contracts which will cheapen service or give any organization control of medical service.

Interest yourself in industrial medicine, if you practice it, and rural problems of accident prevention, if you have an agrarian clientele. It's a public service, now very important in the war effort and will always be a valuable contribution to our economy.

Continue to give your services to the indigent. Temper your charges with mercy at all levels. If you engage in prepay or subsidized medicine, use the same standards as you do in your fee for service practice. Let those schemes rise or fall on their merits not by sabotage, which will only enrage a sensitive public which purports to want and need such agencies.

Cooperation Will Preserve Our Institution

Medicine can and will be united on a common ground by adherence to these principles and will become a force to be reckoned with in any program to clip our wings or hamstring our institutions. Our willingness to cooperate to find a better way, if one exists, will keep medicine the idealistic institution it has always been and what our colleagues returning from war have cautioned us to preserve.

It is apparent from every source that American medicine realizes its responsibility and will, as rapidly as knowledge and experience give direction, take the necessary steps to expand the utilization and available facilities to meet the demand of the American public.

I bid you, as practitioners of medicine in the State of Wisconsin, be vigilant and cooperative to see that Wisconsin medicine continues well in advance of other states on the plane on which medicine is practiced and services distributed. We must always be concerned to keep it on a firm foundation of sociopolitical medical economics because only in that way will the public be served best over a long period of time.

Gentlemen, if I seem reactionary, I hasten to attest to the use of Burton's Rule of Conduct, "I do what my manhood bids me do; and from none but self expect applause."

Erythroblastosis Foetalis and Its Relationship to Transfusion Reactions and Accidents*

By THOMAS A. LEONARD, M. D.
Madison

T. A. LEONARD

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THE last few years have told a fascinating story regarding erythroblastosis foetalis and its relationship to transfusion reactions and accidents, an interesting but heretofore little understood subject. Keen observation and tireless investigation on the part of several individuals have gradually brought to light a much more nearly complete knowledge of erythroblastosis, its cause, and its subsequent effect upon the transfused puerperal mother. An obscure bit of information, which first seemed to be of only academic interest, added to certain previously observed clinical data, aided materially in this study. The story unfolds in chronologic sequence.

Manifestations in the Infant

It had been noted that occasionally babies were born showing a triad of manifestations: icterus, edema, and anemia. It had also been noted that either these babies were born dead or the majority did not survive the immediate neonatal period. In 1932, Blackfan, Diamond, and Baty reported an analysis of 20 cases. They came to the following conclusions regarding the manifestations in the baby:

1. There was universal edema in all gradations from the most severe to just a minimal fluid content over the scalp and extremities.
2. Jaundice was usually present at birth or appeared during the first forty-eight hours. The mahogany-brown jaundice was described as typical.
3. Although early anemic pallor may have been masked by the edema or jaundice, it was always very noticeable by the fifth day.
4. The edema, jaundice, and anemia might be present in all sorts of combinations and degrees.
5. These babies showed marked lassitude and exhaustion, which at times approached semishock. They were difficult to feed and showed a poor weight gain.
6. The heart was uniformly enlarged.
7. The babies showed hemorrhagic tendencies, usually from the intestinal tract by vomitus or bowel but occasionally from the urinary tract or subcutaneously. If there was no noticeable bleeding during life, it was always found at autopsy.
8. Pathologically, there were always extramedullary centers of erythropoiesis and moderate enlargement of the liver and spleen.

Discovery of Pertinent Facts

As more and more cases were reported, important statistical data were analyzed,

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and the following pertinent facts were brought to light:

1. The frequency of erythroblastosis is about eight in every one thousand births.

2. This condition is responsible for about 5 per cent of all fetal mortality.

3. There is a tendency toward familial occurrence. In about 50 to 80 per cent of the cases, if there is 1 case in a family, subsequent offspring will be similarly or more severely affected.

4. There is no race predisposition nor race exemption.

5. About one-third of the mothers of these babies manifest symptoms of toxemia.

6. The mothers show poor weight gain, with a high incidence of hydramnios and decreased fetal activity, which usually terminates in premature labor.

7. There may be amber-colored liquor amnii or golden vernix passed per vaginum during labor or at the time of delivery.

8. The placenta is always very large, heavy, and edematous. This large placenta and the increased density of the soft, edematous tissues of the baby, especially those over the scalp, can often be detected by roentgenography.

Theories as to Cause

After reviewing the foregoing, it was only logical to conclude that a common etiologic factor must be responsible for the occurrence of erythroblastosis foetalis. A number of theories were propounded and will be stated because of their relationship to the factual knowledge to be presented later in this paper:

1. It might be due to a primary metabolic disturbance or to a dominant mutation of the germ cell of either parent.

2. It might be due to a lack of an antihemolytic substance which these babies failed to inherit from their parents.

3. There might occur isoimmunization or passive sensitization of the fetus against his own red blood cells by agglutinins from the maternal circulation.

4. There might be fetal hepatic dysfunction.

In 1940 Landsteiner developed antibodies by injecting the blood of Macacus Rhesus monkeys into rabbits and immunizing them against it. Human red cells were then tested against the serum of these rabbits. It was found that 85 per cent of all persons had in their red blood cells agglutinogens which reacted to the monkey-immunized rabbit serum. The individuals who reacted were designated Rh positive, and the 15 per cent who did not have these agglutinogens were called Rh negative.

The Rh Factor

Transfusion reactions then became the subject for investigation. In 1940 Wiener and Peters investigated a number of transfusion reactions applying the principle of the Rh factor. In their series of cases they found that when an Rh positive donor gave blood to an Rh negative recipient who was later again transfused with Rh positive blood, there were reactions from moderate to severe and even fatal. These reactions did not occur when Rh negative blood was given to Rh negative recipients.

Darrow first suggested in 1938 that erythroblastosis foetalis might be due to an antigen-antibody reaction between the infant's and mother's blood.

Levine and Stetson in 1939 described a fatal transfusion reaction in a woman, never previously transfused, who had just delivered a macerated fetus. They made the suggestion at that time that a dominant immunizing factor might have been inherited from the father by the fetus and that the mother, lacking this factor, was immunized against it by the fetus in utero.

In 1941 Levine showed that 91 per cent of the mothers of infants affected with erythroblastosis foetalis were Rh negative as compared to 15 per cent in the general population and that 100 per cent of the fathers were Rh positive. It is likely, then, that the Rh positive fetus stimulates the production of Rh agglutinins in the blood of the Rh negative mother and that these agglutinins, formed in the mother, gain access to the fetus through the placenta, cause lysis of the fetal red blood cells, and produce erythroblastosis.

The ordinary grouping and cross-matching of the blood of the donor with that of the

recipient do not reveal these subgroup factors. The majority of the hemolytic transfusion reactions have been traceable to the Rh factors, although there have been a few which did not fall into this category and will necessitate further study.

The Transfusion Reaction From the Rh Factor

The transfusion reaction which is caused by the Rh factor is characterized by massive hemolysis, with deposition of hematin in the renal tubules, decreased urinary output, generalized edema, and uremia. In the more severe cases a total anuria, edema, uremia, and death follow. It is felt by some that occasionally the fetal red cells find access through a defective placenta into the maternal circulation and cause hemolysis. If this is extensive, the mother would manifest a toxemia, with its resultant renal dysfunction, edema, albuminuria, hypertension, and the convulsive episodes. This will bear further study.

The most recently published work which has come to my attention is that of Hamilton and Martini of St. Louis, who studied a large group of transfusions in a number of hospitals in St. Louis. In nonobstetric cases the transfusion reactions were 19.4 per cent as compared to 40.6 per cent in the obstetric cases. Whether the blood was taken from the husband or another donor seemed to have no bearing on the reaction. This seems as it should be when we consider that 85 per cent of the population are Rh positive.

Conclusions

1. Erythroblastosis foetalis is a distinct clinical entity characterized by edema, icterus, and anemia.

2. It occurs in the offspring of mothers whose average age is 30 and whose parity is three or more.

3. All of the fathers are Rh positive, while nearly 100 per cent of the mothers are Rh negative.

4. Erythroblastosis foetalis is definitely caused by the hereditary transmission of the Rh positive factor from the father to the fetus and the resultant antibody-antigen reaction between the mother and the fetus.

5. The Rh factor is transmitted to the fetus as a simple Mendelian dominant.

6. The Rh factor is responsible for severe transfusion reactions in the mothers of erythroblastic babies when Rh positive blood is used for the transfusion. Only Rh negative blood should be used for such transfusions.

7. There is the possibility that the Rh positive fetus may have some relationship to the development of a certain group of toxemias.

8. This may have some eugenic significance, in that erythroblastosis foetalis is never the result of matings in which both parents are Rh positive.

BIBLIOGRAPHY

1. Aagaard, G. N.: Transfusion Reactions and Erythroblastosis Foetalis Caused by the Rh Factor, Minnesota Med. 25:267 (April) 1942.
2. Burnham, L.: The Common Etiology of Erythroblastosis and Transfusion Accidents in Pregnancy, Am. J. Obst. & Gynec. 42:389 (Sept.) 1941.
3. Hamilton, E. G., and Martini, A. P.: Blood Transfusions in Pregnancy, Am. J. Obst. & Gynec. 43: 313 (Feb.) 1942.
4. Hooker, S. B.: Isoimmunization in Relation to Intragroup Hemolytic Transfusion Reactions, New England J. Med. 225:871 (Nov. 27) 1941.
5. Landsteiner, K., and Wiener, A. S.: Studies on Agglutinogen (Rh) in Human Blood Reacting with Anti-Rhesus Sera and with Human Isoantibodies, J. Exper. Med. 74:309 (Oct.) 1941.
6. Levine, P., and others: The Role of Iso-Immunization in the Pathogenesis of Erythroblastosis Fetalis, Am. J. Obst. & Gynec., 42:925 (Dec.) 1941.
7. Levine, P., and others: Immunization in Pregnancy, J. A. M. A. 116:825 (March 1) 1941.
8. Platou, R. V.: Erythroblastosis Foetalis, Journal-Lancet 61:151 (May) 1941.
9. Editor: Incompatible Blood Transfusion and Rh Factor, Brit. M. J., p. 153 (Jan. 31) 1942.
10. Editorial: Isoimmunization, J. A. M. A. (Jan. 10) 1942.

INTERSTATE POSTGRADUATE MEDICAL ASSOCIATION

The Twenty-Eighth Annual Assembly of Interstate Postgraduate Medical Association is scheduled for October 26, 27, 28 and 29 at the Palmer House in Chicago.

Scientific exhibitors from Wisconsin are: Dr. G. V. I. Brown, Milwaukee; Dr. V. B. Hyslop, Madison; and the University of Wisconsin Medical School, Madison.

Wisconsin physicians contemplating attendance should make early hotel reservations.

Management of Toxemia in the Last Trimester of Pregnancy*

By WARNER S. BUMP, M. D.
Rhinelander

W. S. BUMP

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THERE has been much confusion in regard to the so-called toxemias of pregnancy. In a short discussion one cannot review the literature and weigh controversial matters. One must present his own selection of what seems important and worthwhile in the light of his own experience.

My first actual contact with eclampsia was at the necropsy table with the late great pathologist, E. R. Le Count. The fatty changes, the petechial hemorrhages, and the areas of necrosis in that liver are still pictured clearly in my mind. My interest in eclampsia has continued ever since that time.

Important Conceptions Regarding Toxemia

From the literature pertaining to the toxemias of pregnancy, certain clear-cut conceptions seem important. It is clear that pregnant women may have essential hypertension or vascular-renal disease which existed before the pregnancy and that such disease is not dependent upon the pregnancy. It is also clear that there is a specific syndrome entirely peculiar to pregnancy and developing in the last trimester which begins with undue gain in weight and is usually associated with edema, elevation of the arterial blood pressure, and albuminuria. This condition may progress with headache, visual disturbance, vertigo, and epigastric distress to convulsions and coma. This syndrome of preeclampsia and eclampsia may be superimposed upon a previously existing essential hypertension or vascular-renal disease, for women with such disease are predisposed to this toxemia, or, as is more commonly the case, it arises in previously normal women. Finally, it is clear that even though mild preeclampsia occurs in spite of good management, the more severe forms and eclampsia itself nearly always can be prevented. And prevention is the better part of treatment.

Normal pregnancy grades almost insensibly into pregnancy with toxemia. About 60 per cent of normal pregnancies are accompanied by varying degrees of edema. Women without edema rarely have toxemia. According to various observers,[1, 2] anywhere from 10 to 50 per cent of women with edema develop toxemia, and it has long been known that an undue gain in weight is a precursor of toxemia. Much of this weight-gain may be due to edema whether it is grossly apparent or not.

The onset of vascular constriction and renal glomerular changes may cause no symptoms. Of 60 patients with toxemia, observed by Dexter and Weiss,[1] 28 had no symptoms, and the toxemia was unsuspected until the blood pressure was recorded and the urine examined for albumin. This is common experience.

Prevention of Toxemia

The prevention of serious preeclampsia and eclampsia is logically based upon measures to combat any undue gain in weight with retention of water and sodium and con-

* Presented before the One Hundred First Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1942.

tinual vigilance to detect the first signs of toxemia.

The recording of the weight and blood pressure, search for evidence of edema, and examination of the urine should be carried out routinely at regular visits, beginning with a complete physical examination as early in pregnancy as possible. Thus, those patients with essential hypertension and vascular-renal disease and the larger group of normal patients with edema are recognized early. The diet should be adequate for nutrition but not one which may cause an undue gain in weight. Protein should be maintained at 100 Gm. or more per day. Lean meat, eggs, milk, and abundant fruits and vegetables are indicated. Fat and salt should be restricted, especially so if the gain in weight is more than 250 Gm. (about ½ pound) per week. If the weight-gain exceeds this figure and also during the latter half of most pregnancies, the diet should be low in salt or even salt-free, and medicinal preparations containing sodium should not be used. These measures, together with sufficient rest, usually suffice to prevent the more severe forms of edema and preeclamptic toxemia.

Management of Mild Toxemia

When mild toxemia is discovered, that is, when the blood pressure rises to about 140 to 160 mm. systolic and 90 to 100 mm. diastolic and there is less tnan 0.6 Gm. of albumin per 100 cc. of urine, the patient should be seen at least once or twice per week. She should bring a sample of the measured twenty-four hour urine output for quantitative albumin determination. The diet advised by Dieckmann[3] is satisfactory. It is made up of 60 Gm. of protein, 30 Gm. of fat, and 400 Gm. of carbohydrate with less than 1 Gm. of sodium salt. The patient should have adequate rest at night with periods of rest during the day. Small doses of phenobarbital are often indicated, and, if there is much edema, ammonium chloride may be given in doses of 1 Gm. six to eight times per day.

Begun early, such management usually prevents further increase in the severity of the symptoms. I have examined the records of the last 500 patients whose prenatal periods I supervised essentially as described. None developed eclampsia, and only 4 developed severe toxemia. In one of these instances, the toxemia was superimposed upon a chronic vascular-renal disease. In another instance, it arose in a patient whose blood pressure and urine were normal during the early months of pregnancy but who gave a definite history of acute nephritis five years before. All of these 4 recovered without developing convulsions, but there were two fetal deaths.

The incidence of eclampsia in England is 1.61 per cent, in South Carolina 2.55 per cent, and in Wisconsin 0.42 per cent. Of course, the incidence of severe pre-eclamptic toxemia is considerably higher in each instance. At the Chicago Lying-In Hospital between 1931 and 1940, when the prenatal management was much as I have outlined, the incidence of eclampsia was 0.32 per cent and of nonconvulsive toxemia 7.4 per cent.[3]

Severe Preeclampsia

If, in spite of this management or perhaps through lack of management, the findings of severe preeclampsia develop with the blood pressure above 160 mm. systolic and 110 mm. diastolic and with the urine-albumin over 0.6 Gm. per 100 cc.; if there is marked edema especially of the face; if the weight suddenly increases 2 pounds or more per week; or especially if there are cerebral, visual, or gastrointestinal symptoms, hematuria, or oliguria, hospitalization is clearly indicated.

In the hospital the twenty-four hour urine output is measured daily, and a specimen is examined. The blood pressure is recorded three times per day, and a strict 1,200 calorie diet of fruit, fruit juices, and sugar is instituted.

Indications for Terminating the Pregnancy

According to Dieckmann,[3] the average mortality for ante partum eclampsia in the United States is 21 per cent, while it is only 1.7 per cent for nonconvulsive toxemia. While the ultimate cause of pre-eclampsia and eclampsia is not known, it is known that there can be no eclampsia without the placenta, except for a short time post partum.

Therefore, it is obvious that when the toxemia is progressively severe, it may be most desirable to empty the uterus and thus avoid the high mortality of eclampsia. Hilgenberg[4] found that medical management of severe pre-eclampsia resulted in 36 per cent of the patients developing eclampsia, while termination of the pregnancy resulted in 10 per cent developing eclampsia.

Dexter and Weiss[1] place considerable stress on an insidious, unexplained, progressive fall in the arterial pressure as the earliest sign of impending disaster indicating that convulsions are imminent. Diechmann's[3] indications for terminating the pregnancy are clear and logical. They are based upon the duration of the pregnancy, the condition of the cervix, and the following two groups of signs:

"A. The systolic blood pressure is constantly 170 mm. Hg. or shows a persistent daily increase.

A. The proteinuria always exceeds 5 Gm. per twenty-four hours or the qualitative test of the twenty-four-hour urine is three-plus.

A. The weight gain exceeds 100 Gm. per day.

A. Marked edema suddenly occurs.

B. Cerebral, visual, or gastrointestinal symptoms arise.

B. Oliguria, anuria, or hematuria occur.

B. Jaundice develops.

B. The blood nonprotein nitrogen is 50 mg. per cent or more.

B. The pulse rate is 120 or more.

B. Edema of the lungs or cyanosis is present.

B. The blood shows an increasing concentration as indicated by an abnormally high or increasing hemoglobin, cell volume, serum protein concentration, or specific gravity.

"Gestation of twenty-six weeks or less should be terminated if more than one of the above listed criteria are present or if there is no appreciable improvement after seven days of adequate treatment.

"Gestation of twenty-seven to thirty-one weeks should be treated medically until thirty-two weeks, unless some 'B' signs develop or the 'A' signs persist despite treatment or increase in degree.

"Gestation of thirty-two to forty weeks, if 'B' signs are absent, should be treated medically until the cervix is 'ripe,' when induction of labor will be successful. If the 'A' signs increase in degree or if any of the 'B' signs appear, the pregnancy should be terminated by (1) rupture of the membranes and/or the insertion of a bag, or (2) cesarean section if the cervix is uneffaced and closed.

"Our results indicated that the careful medical management of the toxemic patient, if begun early enough, will usually prevent further increase in the severity of the symptoms and signs until the cervix is 'ripe.' This means that labor can usually be successfully induced by rupture of the membranes."

Another reason for the termination of pregnancy is the possibility of permanent vascular-renal disease from prolonged toxemia. Gibberd[5] and also more recently Dexter and Weiss[1] have stated that sustained hypertensive vascular disease may be initiated by toxemia of pregnancy. They believe that toxemia should not be allowed to persist for more than three weeks. Dieckmann[3] is not in accord with this view.

Including the cases referred to me at the hospital, I have treated 10 patients with severe pre-eclampsia. Four went into spontaneous premature labor during the course of medical treatment. Labor was induced in 3, and three cesarean sections were performed. The maternal mortality was zero, but there were two fetal deaths, the ones previously mentioned. Both of these deaths occurred after spontaneous labor. One of the two babies was born alive but died after three hours because of prematurity; the other was stillborn. Two cesarean sections were done because of the symptoms of impending eclampsia in primiparae with long closed cervices. The third cesarean operation was performed because of severe toxemia superimposed upon a chronic vascular-renal disease. The maternal and fetal mortality following the sections was zero.

Eclampsia

When convulsions do occur, the danger to the patient becomes great, and the considerations for treatment become somewhat paradoxical. Eclampsia occurs only in the presence, or very recent presence, of living chorionic tissue. Therefore, the obvious course is the removal of that tissue as soon as possible. On the other hand, the eclamptic patient is in a critical condition which brings about a staggering mortality from immediate emptying of the uterus by such measures as accouchement forcé or cesarean section.

Logically then the proper treatment of eclampsia should aim at the emptying of the uterus by the safest means when the condition of the patient is sufficiently good to tolerate the procedure. Such a concept of treatment entails medical measures before any mechanical interference. This therapy consists of general care and rest, sedation, and especially the production of diuresis. Water-retention and progressive renal shut-down cause cerebral edema, pulmonary edema, cardiac decompensation, and circulatory collapse. Diuresis is the most reliable sign of improvement, and, according to Dexter and Weiss,[1] improvement does not take place until diuresis occurs.

Dieckmann's Treatment of Eclampsia

I like the treatment recommended by Dieckmann, for it takes into consideration these basic principles. He outlines the general care as follows: "The patient is placed on her side without a pillow under her head, in a quiet, cool, darkened room. Constant observation is necessary to prevent injury to the tongue, falling out of bed, aspiration of vomitus or drowning from the occasional excessive pulmonary secretions. A catheter and aspirating machine should be available for removal of fluid from the throat. A mouth gag (clothes pin, tooth brush) should be at hand. A catheter should be kept in the bladder until the patient is definitely improving. The temperature, pulse and respiratory rate, urine volume, and blood pressure should be determined every hour until the patient is conscious and improving. This period is then lengthened to four hours and later the intervals are increased still further. The patient's condition as to the number of convulsions, the degree of coma, the quality of pulse, difficulty in breathing, cyanosis, etc., should be noted."

For sedation Dieckmann[3] uses several drugs simultaneously, because smaller doses of each are required, and thereby the undesirable effects of each are minimized. He prefers magnesium sulfate and luminal sodium and gives 10 cc. of a 50 per cent solution of the former into the gluteal muscles on admission and repeats with doses of 2 cc. after each convulsion until the convulsions cease or a maximum of 20 cc. have been given in twenty-four hours. Five grains of luminal sodium are injected subcutaneously, and this is repeated, if necessary, in twelve hours.

Morphine in 0.25 grain amounts may be given at hourly intervals until the convulsions are controlled or respiration drops to 10 per minute. Chloral hydrate, 2 Gm. in 100 cc. of starch water, may be administered by rectum and repeated as necessary. Dexter and Weiss[1] advise against large amounts of morphine and believe that chloral should be used for only very short periods.

For diuresis Dieckmann[3] gives an intravenous injection of 500 to 1,000 cc. of 20 per cent solution of glucose over a period of thirty to fifty minutes and repeats this every six to eight hours. If the urinary output is not at least 30 cc. per hour or the output for the first four hours is not at least 60 per cent of the amount injected, smaller amounts of 30 per cent or even 50 per cent glucose are administered.

Blood or plasma transfusion, according to Dexter and Weiss,[1] is the most important measure for checking circulatory collapse and may aid in producing diuresis. Venesection is definitely harmful. It is important to give the transfusion slowly (500 cc. in two or three hours) with the patient in the orthopneic position to avoid the tendency to cardiac asthma or pulmonary edema.

When severe paroxysmal dyspnea, asthma, or pulmonary edema occurs, rapid digitaliza-

tion is indicated. Weiss[1] advises the intravenous administration of 0.5 mg. of strophanthin or 0.5 to 1.0 mg. of digitoxin. If the pulmonary edema is due to congestive failure, not circulatory collapse, the application of tourniquets about the extremities is indicated or even venesection with the removal of 500 cc. of blood.

Nothing should be given by mouth when the patient is having convulsions or is in coma. Later, water and fruit juices are indicated.

If the eclampsia is mild and controlled by treatment, Dieckmann does nothing more until the cervix is "ripe," that is, soft, effaced, and partly dilated. Then, if labor does not ensue spontaneously, it is induced by rupture of the membranes with or without insertion of a bag. Of course, in the presence of cephalopelvic disproportion, cesarean section is performed.

Findings Present in Severe Eclampsia

It is of great importance that there be definite criteria for recognizing severe eclampsia. According to Dieckmann,[3] the eclampsia should be considered severe if one or more of the following findings are present:

"(1) Coma.
(2) Temperature of 39 C. (102.2 F.) or more.
(3) Pulse rate over 120.
(4) Respiratory rate over 40.
(5) More than ten convulsions.
(6) Cardiovascular impairment (edema of the lungs, persistent cyanosis, low or falling blood pressure, and low pulse pressure.)
(7) Failure of treatment
  (a) To stop the convulsions or prevent their recurrence.
  (b) To produce a urinary output of at least 700 cc. per twenty-four hours.
  (c) To prevent the onset or increase in degree of coma.
  (d) To produce a dilution of the blood as indicated by a decrease of at least 10 per cent in hemoglobin, cell volume, or serum protein concentration."

When the eclampsia is severe, the pregnancy should be terminated after eight to twelve hours of medical treatment by rupture of the membranes with or without the insertion of a bag, provided the cervix is "ripe." If the cervix is long and closed and the gestation is of twenty-three weeks or over, cesarean section is indicated.

The treatment of postpartum eclampsia is, of course, entirely medical as outlined previously. Dieckmann's mortality in 27 cases was zero.

The average mortality for ante partum eclampsia is 21 per cent for the United States. The average for all types of eclampsia is 14 per cent. At the Chicago Lying-In Hospital for a very recent nine year period there were 75 cases of eclampsia treated according to Dieckmann's description. The maternal mortality was 6 per cent and the fetal mortality 26 per cent. This mortality is low and much better than the United States average.

I have treated 8 patients with eclampsia, all of the antepartum type and all referred to me at the hospital. This small series is not truly representative of the results of Dieckmann's treatment, with which I am heartily in accord, for most of them occurred when more emphasis was given to sedation and less to the production of diuresis. Four of these were primiparae with long closed cervices and were subjected to cesarean section without waiting for the cervix to become soft and effaced. Happily, the maternal and fetal mortality was zero. Three were treated conservatively; 2 went into spontaneous labor, and in the third labor was induced. One baby recovered, one was born alive but died in two and one-half hours because of prematurity, and the third was stillborn. The eighth patient, representing the only maternal death, was moribund on entrance. The pulse was very rapid and almost imperceptible. She was in deep coma, with marked cyanosis, gasping respiration, and cold clammy extremities. According to Weiss, such findings usually mean irreversible changes. She died two and one-half hours after entrance.

Dexter and Weiss believe that the maternal mortality for eclampsia can be reduced

to somewhere between 1.5 per cent and 4 per cent by the careful application of treatment similar to that outlined in this paper.

Summary

The management of toxemia in the last trimester of pregnancy should begin as early as possible in pregnancy with measures to prevent undue gain in weight and the retention of water and sodium. The diet should be adequate in protein but low in fat and salt. Severe preeclampsia seldom should develop and, if adequately treated, only rarely should result in eclampsia. When eclampsia does occur, treatment should aim at the emptying of the uterus by the safest means only after proper medical care. The principles of this care are the production of diuresis and the control of convulsions by proper sedation. The better the medical care, the more often may the uterus be emptied by conservative means.

BIBLIOGRAPHY

1. Dexter, L., and Weiss, S.: Preeclamptic and Eclamptic Toxemia of Pregnancy, Boston, Little, Brown and Company, 1941.
2. Wielock, J.: Ueber Eklampsie unter Berücksichtigung der Hirndrucktheorie, Arch. f. Gynak. 120:72, 1923.
3. Dieckmann, W. J.: The Toxemias of Pregnancy, St. Louis, C. V. Mosby Company, 1941.
4. Hilgenberg, F. C.: Zentralbl. f. Gynak. 56:3006, 1932.
5. Gibberd, G. F.: Albuminuria Complicating Pregnancy, Lancet 2:520 (Sept. 5) 1931 and 121:576 (Sept. 12) 1931.

DISCUSSION

James W. McGill, M. D., Superior

Dr. Bump has given an excellent presentation of a perenially important subject. It is difficult to discuss this type of paper because of the thorough and painstaking manner in which the problem has been covered and especially when the author's ideas so closely approximate one's own. Furthermore, in bringing to us the findings and opinions of Dieckmann in his monograph, "The Toxemias of Pregnancy," and Dexter and Weiss's book, "Preeclamptic and Eclamptic Toxemia of Pregnancy," the author has given us the most recent and authoritative work that exists in medical literature on these disease entities.

I feel that all I can do is to attempt to reemphasize some of the important points brought out by Dr. Bump. The excellent statistics presented concerning the incidence of eclampsia highlight the value of preventive medicine. While it is true that some progress has been made in the treatment of these two closely allied conditions, such as the use of hypertonic glucose for the initiation of diuresis, the fact that eclampsia is becoming a rare disease is a triumph of prophylaxis. Probably no other single factor is so important in the improvement in these figures as prenatal care. Thus is Dr. Bump's statement borne out: "The more severe forms of preeclampsia itself nearly always can be prevented."

Titus makes two interesting observations: first, that primiparity, multiple pregnancy, and hydramnion show an increased incidence of eclampsia and, second, that the prognosis is poorest in "dry" eclamptics, patients who have the least edema.

It is generally recognized that salt seems to aggravate the toxicity of these conditions; in the matter of treatment, therefore, it is a practical point worth remembering that when hypertonic glucose is given for the purpose of inducing diuresis, the solution should be made with distilled water rather than with salt solution. Dr. Bump very properly stresses the harmful results of venesection; many of these patients are anemic to begin with, and loss of blood may have serious consequences. Arnold and Fay make a practical suggestion: in establishing a fluid balance, the fluid intake for a day must not exceed the urine output for the preceding day.

There is pretty general agreement that evacuation of the uterus at the earliest practicable time following the onset of convulsions is in line with good obstetric thought and practice. This has as its purpose not only the immediate welfare of the patient but the prevention of permanent vascular and renal damage, a worth-while objective in itself. This question of evacuation of the uterus raises the ever-interesting problem of the method of evacuation, which in turn leads to a consideration of cesarean section, about which I should like to say a word. There are cases in which delivery by section undoubtedly constitutes the best possible treatment. There are, just as unquestionably, cases wherein cesarean operation is the most unfortunate choice. Just where the dividing line is to be drawn always calls for painstaking consideration.

I believe that there are instances wherein, in seeking to treat the disease, we may lose sight of the patient who has the disease. Operation upon an unprepared patient with an unfavorable blood chemical picture is just as illogic in eclampsia as prostatectomy would be in a patient with urinary obstruction but on the brink of uremia.

Schumann says that cesarean section has a limited but a very definite place. It "is indicated in only a small proportion of cases, but it is equally true that when indicated it is a life-saving measure of the greatest value." He is outspoken in favoring local anesthesia for operation. Mussey and Randall say that "infrequently, cesarean section may be indicated . . ." Stander states: "Cesarean section is very seldom indicated in the treatment of eclampsia." Titus points out that "the highest maternal death rates are among those women treated by prompt cesarean

section or other operative measures, (20 per cent), and the lowest rates, (about 5 per cent), among those treated conservatively by medical measures."

It is not my purpose to be dogmatic in the matter of cesarean operation nor to be critical of its employment in specific instances. Indeed here, if anywhere, treatment must be determined by the circumstances of the individual case. But I believe that cesarean section should be a rare, rather than a common, method of emptying the uterus in eclampsia.

Heart Disease and Pregnancy*

By JULIUS JENSEN, M. D.
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WITH the many dramatic and revolutionary advances of modern medicine, we tend to lose sight of many gradual, less conspicuous, but not less significant, changes which are brought about rather by better understanding of the problems than by brilliant discoveries of new facts. The declining death rate from the complications of heart disease with pregnancy is a case in point. It is one of the rewards of expanding prenatal care and the application of newer cardiologic knowledge to obstetrics.

Originally, pregnancy was a most dreaded complication of heart disease. The patients were not seen until pregnancy was far advanced or perhaps until labor had already started. If the heart remained compensated, no attention was paid to it, but if it became decompensated, the situation was often so desperate that quick relief to the heart by prompt removal of the ovum seemed to be the only remedy. The results were too often disastrous.

This state of affairs is now greatly changed. We have learned much about the manner in which the pregnancy places increasing demands on the cardiovascular system as it progresses and of the hemodynamics of labor. We have developed the art of cesarean section and surgical anesthesia to a point where strain on the cardiovascular system can be greatly diminished. We have also learned something about the diagnosis of early heart disease and of its natural history, a knowledge which enables us to avoid difficulties which formerly proved serious.

Pregnancy Increases Heart Load

Pregnancy, then, increases the work of the heart in various ways. Most obvious are the increase in weight and the necessity of overcoming the strain of postural changes which accompany it. Besides these, there are other factors less easily understood. In pregnancy the metabolic rate is increased, often out of proportion to the increase in weight. Insofar as this increase in metabolism is an expression of endocrine (especially thyroid) activity, it may well be a cause of cardiac overwork.

The volume of the circulating blood is increased, often out of proportion to the increase in weight. Moving this increased load of blood adds to the work of the heart.

The heart meets this extra demand by increasing its minute volume. It has not been definitely decided to what extent this is accomplished by increasing the rate or the stroke volume of the heart. There is some evidence that perhaps not all hearts accomplish their tasks in exactly the same manner.

Sufficiency of Cardiac Reserve

In order to accomplish the extra amount of work demanded by the pregnancy, the

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heart must draw upon its reserve. Therefore, the whole problem of pregnancy in heart disease resolves itself into one of sufficiency of cardiac reserve. Inasmuch as we cannot exactly measure the amount of reserve nor predict how it may change as pregnancy advances, the prognosis of this complication remains uncertain. It seems that to some extent, at least, the healthy heart undergoes a physiologic hypertrophy, but this also remains a disputed point. To complicate the picture further, sometimes even the strength of the normal heart proves inadequate to the demands of pregnancy, and a picture of congestive failure ensues which often cannot be distinguished from that of heart failure in organic heart disease. The prognosis of the condition is generally favorable.

Rheumatic Heart Disease

Rheumatic heart disease is the form of heart disease which traditionally has caused most concern. One of the fundamental difficulties in the condition has been the problem of diagnosis. Nowhere else has the importance of correct interpretation of murmurs been greater, especially because the pregnant state itself seems to encourage the development of certain murmurs, especially over the base of the heart. Time does not here permit the discussion of the many diagnostic pitfalls of cardiac diagnosis in pregnancy. As a matter of fact, the accuracy of diagnosis, or lack of it, is one of the factors which determine statistical results which are so important in these studies.

When the diagnosis of rheumatic heart disease has been made in a pregnant woman, the treatment depends on a correct prognosis. The tendency through this century has been towards increasing conservatism. The indications for interruption of the pregnancy or for drastic obstetric procedures, including cesarean section, have become fewer.

If the patient is young, if only the mitral valve is affected, if the heart is not much enlarged, if the action is regular, and if the response to effort is good, the chances that she will pass through pregnancy and deliver without complications are good. Only a small percentage of such patients develop cardiac complications. The two most feared are acute pulmonary edema and subacute bacterial endocarditis.

A number of findings render the prognosis less favorable; some of them affect the cardiac prognosis apart from the presence of pregnancy, but that does not alter the outlook of the pregnant woman.

The Age Factor

We know that relatively few patients with rheumatic valvular heart disease survive the childbearing age. In these patients, as a group, the death rate during a given period increases as age advances. If that period be that of gestation, it follows that the older the patient the more likely is she to suffer cardiac complications as the pregnancy advances. This natural tendency is further aggravated by progressively increased demands upon the heart by the pregnant state. The age about 30 seems to be the period when age makes itself definitely felt. Consequently, the older the patient, the less conservative should be the management for the less resiliency does the heart retain.

This factor of age has been confused with that of parity. One has heard reference both to the elderly primigravida and to the multipara who, over many years, has become worn out by childbearing. Ignoring the obstetric implications of these terms and many theoretic factors which cannot here be discussed, it may be stated that there is no conclusive evidence as yet that parity by itself has any effect on the outlook of the patient with cardiac disease. This relationship can be proven only by statistical studies, and even the most extensive material available at the present time has failed to support its existence. We may express this same fact differently by stating that there is as yet no evidence that pregnancy has any lasting influence on rheumatic heart disease.

Cardiac Enlargement

The other group of factors which may affect the prognosis adversely are chiefly concerned with the advances of the heart disease. As the heart disease advances, it becomes more susceptible to failure in its vari-

ous manifestations. Consequently, as we discern the changes which indicate advance, the outlook becomes less favorable, especially as they become concerned with cardiac reserve. The most obvious of these factors is cardiac enlargement of marked degree. The clinical impression of slight or even moderate enlargement is not so important, because there is a mild physiologic cardiac hypertrophy in pregnancy, and the pregnant state will cause displacement of the apex beat and of the roentgenogram shadow, all of which may simulate pathologic enlargement. Therefore, unless cardiac enlargement is beyond question, it, in itself, need not affect the prognosis.

Generally, auricular fibrillation is associated with the late or even last stages of the rheumatic heart disease and, consequently, is of the greatest importance; the death rate among pregnant women with this condition is ten times that of pregnant women with regular hearts. However, before such somber implication be attached to auricular fibrillation, one should make sure that it is a late complication of rheumatic heart disease and not one of the more innocent forms of the arrhythmia. The involvement of the aortic valve also adds to the gravity of the prognosis; such patients seem to be particularly susceptible to bacterial endocarditis.

Uncertainty of Prognosis

All these factors are important because of their bearing on the cardiac reserve, sufficient impairment of which will result in congestive failure. A mystery still surrounds the essential nature of this event. We do not know what actually induces it; we know that all the changes which we have discussed favor its occurrence, but they do not necessarily cause it. This explains why patients with evidence of the most advanced cardiac changes occasionally pass through pregnancy and labor without trouble, contrary to all expectation. The lesson drawn from this fact is that a prognosis of certain disaster should never be made; the element of chance is always too great.

Nevertheless, the danger of congestive failure should always remain in our minds when we are taking care of pregnant women with rheumatic heart disease. Therefore, such patients should be seen by someone trained in cardiology throughout their prenatal care and postpartum course. If all is well, monthly visits may suffice. At these visits, inquiry should be made into the general health of the patient. Specifically, she should be questioned in regard to increasing dyspnea, insomnia, chronic cough, swelling of the feet, and physical endurance. In the physical examination, special attention should be paid to the weight, excessive increase of which may betray retention of excess fluid in the body, the heart rate, the ankles, and the bases of the lungs where persistant rales may be the first harbingers of pulmonary congestion.

As long as the patient with cardiac disease shows no signs of congestive failure, pregnancy should proceed normally. As a precaution, she may be instructed to treat colds most carefully and to limit her activities to what she can do without fatigue. Her periods of rest should be somewhat longer than for the pregnant woman with a healthy heart. However, excessive restrictions, such as complete rest in bed for several weeks before labor, may be harmful, for patients passing into labor should be in the best physical condition which their handicap will permit. Exercise within their capacity serves this purpose better than complete rest.

If the patient shows evidence of failure any time during the prenatal course, the failure should at once be treated with the greatest energy. The patient should at once go to bed and remain there in the position which she finds most comfortable; she should receive sedation and digitalis and such other treatment for congestive failure as may be indicated. The main principle is to treat even the earliest failure with far greater strictness than one would were the patient not pregnant. Generally, compensation is obtained the more easily the earlier the failure is treated.

If compensation is readily regained, as it often is, the patient should return to moderate activity for the remainder of her pregnancy, but she should be watched much more closely than before the break.

Effect of Decompensation

The outlook is profoundly affected by the appearance of decompensation. Generally speaking, it is worse the earlier in pregnancy decompensation occurs and the less readily it responds to treatment. Sometimes the failure has been precipitated by an acute cold or a transitory strain. In such cases, compensation may be readily regained when the cause is removed, and in them the outlook is much better than it is when failure occurs, because the heart fails under the increasing load of pregnancy.

When cases are thus handled, disasters should be rare, as in fact they are in modern hospitals. Here they usually occur in neglected and mismanaged cases which are admitted to the hospital long after the chances of doing good have passed. Even in these an effort should be made to obtain the best possible effects of medical treatment before resorting to obstetric measures.

Resorting to Special Obstetric Measures

Only when medical treatment has failed or when mild decompensation remains after the physician has done his best should interruption of the pregnancy be considered. During the first trimester it presents no special medical problems, but as pregnancy advances, and especially as the chances of obtaining a live baby increase, the responsibility of the physician increases also. If the patient can be kept going, even in partial heart failure, and the fetus can be kept going also until the thirty-sixth week, the chances for a viable child are greatly increased. After this time, therefore, the physician is much more ready to agree to artificial termination of the pregnancy.

The problem has never been satisfactorily solved as to whether prematurely induced labor is preferable to cesarean section. This operation apparently grew to undeserved popularity a few years ago, but now it seems to be finding its level.

The Postpartum Period

Bearing in mind the old saying that a baby in the crib may be a greater load than a baby in the womb, the physician should be sure that, following delivery, patients with cardiac disease receive their full measure of rest before they resume domestic duties. In fact, during this period it is time to go into the entire problem of the patient's home conditions, her physical and environmental resources, and the question of future pregnancies. Experience shows that the postpartum period is the most favorable time to discuss with the patient the advisibility of contraceptive measures and, in some cases, the question of sterilization.

The close adherence to these principles has greatly improved the outlook of the patient with cardiac disease who becomes pregnant. She will, however, continue to present a problem beyond that of pure obstetrics, for she is always liable to complications of her own, notably acute pulmonary edema and infections of the lungs. A small percentage develop bacterial endocarditis. In these cases little, if anything, is gained by premature interruption of the pregnancy; rather, all efforts should be directed toward supporting the mother through the remaining period of gestation. Chemotherapy should be tried, but it has so far proved generally disappointing.

STATE BOARD OF MEDICAL EXAMINERS—SPECIAL EXAMINATION

The State Board of Medical Examiners will hold a special examination for the convenience of interns about to enter service in Madison on Monday, Tuesday, and Wednesday, December 13, 14, and 15.

Resuscitation of the Newborn Infant*

By WILLIAM C. KEETTEL, M. D.
Madison

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WHEN asphyxia neonatorum is mentioned, we frequently think only in terms of the asphyxia produced by the analgesic drugs used during the course of labor. While this is extremely important, Kosmak[1] and others have pointed out that the causative factors are very numerous and that often it is a combination of factors. For example, asphyxia may result from prolapse, pressure and knots of the cord, placental separation and uterine tetany; or from trauma of operative delivery, sudden compression or release of the head passing through the birth canal, prematurity with defective respiratory development, and from analgesics and anesthesia given the mother.

Further evidence of the importance of this complication is shown by the fact that 22.7 per cent of the babies born in Wisconsin during 1940 showed some degree of asphyxiation. The work of Schreiber[2] and others lends additional weight to the seriousness of this complication not only as an important cause of neonatal deaths but also because of the permanent central nervous system damage produced in a certain percentage of the infants that survive.

It at once becomes apparent that our every effort should be directed toward preventing asphyxia neonatorum whenever possible. Wisconsin is indeed fortunate that much of the preventive investigation has been done at our own state university by Doctors Lund,[3, 4] Waters and Harris.[5] They have emphasized the importance of recognizing that certain factors predispose to asphyxia. Such factors as primiparity, prematurity, presentation and position, prolongation of the first and second stages of labor, operative deliveries, and analgesic drugs should always be kept in mind.

They have also emphasized the importance of frequent auscultation of the fetal heart sounds in determining impending fetal asphyxia and the institution of oxygen as specific therapy. Oxygen administered to the mother will either partially or completely restore the fetal heart rate to normal and successfully combat anoxia in many cases. Lund[3] points out that "the response to oxygen therapy should be noted within ten minutes and frequently is apparent in less than five minutes. If after fifteen minutes of therapy no improvement is noted, it may be assumed that oxygen will be of no value. The time of preparation of a patient for operative delivery is usually not more than ten minutes, and this can be carried out while the oxygen is being given; thus no hazard is created for the infant. Frequently the improvement in the fetal heart rate will obviate the necessity of exigent operative delivery and its danger to mother and infant."

Despite all these important advances, we cannot prevent all cases of asphyxia neonatorum; hence, the balance of this discussion will deal with the more common methods of resuscitation now employed.

Artificial Resuscitation

In the past, many heroic and often brutal methods were advocated, such as the Schultze swingings or the folding of the infant's body upon itself. Gradually these methods were abandoned when it was shown that often serious and fatal damage was produced. At the present time, the only form of

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artificial resuscitation that can be recommended is gentle cutaneous stimulation of the mildly asphyxiated infants who have good muscle tone. In the more severely asphyxiated infants who have poor muscle tone, any form of cutaneous stimulation is useless and is to be condemned. No matter how much these babies are stimulated, respiration will not be established until the airways are cleared, heat is supplied, and oxygen administered.

Application of Heat

The very simple but extremely important procedure of supplying external heat is all too frequently omitted. It should be remembered that these infants, particularly the severely asphyxiated, are in a state of shock and should be treated accordingly. All too often we see the baby left exposed on a cold table while all sorts of new devices are used to resuscitate the newborn child. During this time the condition of the infant may have become critical simply because external heat was not applied.

The asphyxiated baby should be kept warm immediately following delivery, and this means that either warm blankets or a heated crib should be readily available. The use of hot water bottles is to be avoided, for no matter how well the bottles are protected, severe burns may result. Immersion of the baby in a tub of hot water is very frequently employed and is particularly useful in the small hospital or in home deliveries. Alternate immersion in hot and cold water has the authority of long custom; despite this fact we cannot condemn strongly enough the use of cold.

Removal of Mucus

Immediately following the delivery, the baby should be held by its feet and the mucus milked out of the pharynx. The mouth should be cleaned with the gloved finger or wiped out very gently with a small piece of sterile gauze. If gauze is used, care must be exercised so that the delicate mucous membranes are not traumatized. This procedure will suffice in the mildly asphyxiated baby. In the more severe cases, it is necessary to use a catheter and suck the mucus, amniotic fluid, and secretions from the nasopharynx and pharynx. This should always be done first before any attempt is made to bring air into the lungs; otherwise, these foreign substances will be forced still further down and may give rise to atelectasis and pneumonia. A woven catheter with a mucus trap, such as the one devised by the late Dr. De Lee, is extremely useful.

Gas Therapy

It is not within the scope of this paper to enter into an extensive discussion as to whether oxygen alone or oxygen combined with 5 per cent carbon dioxide should be used. Both have their advocates, and, with both, seemingly good results are obtained. The gas is most frequently supplied to the infant by means of a mask while respiratory movements are produced by gently compressing and relaxing the thorax. When a mask is used, one must be very careful that the lower jaw is not depressed; otherwise, the baby's air passages may be obstructed.

When gas is not available, mouth to mouth breathing is a very practical and valuable method of resuscitation. The baby's mouth is covered with several layers of gauze, the head is slightly extended, and air is blown into the baby's airways. One should be careful not to use too much pressure, as there is danger of rupturing the alveoli. Others have mentioned the dangers of respiratory infections transmitted by this procedure. However, if care is exercised with this method, it should not be harmful to the baby and is often a life-saving measure.

Intratracheal Catheterization

This method has been used to a limited extent for many years, but it has only been in recent years that it has enjoyed such wide popularity. There are two methods of introduction of the tracheal catheter: one by direct visualization; the other by blind palpation. In direct visualization, the larynx is viewed directly by a laryngoscope, and the catheter is inserted between the vocal cords. With the other method, a finger is placed into the baby's mouth feeling for the epiglottis, which is swung forward, and the aryte-

noid cartilages are palpated. The catheter is then introduced under the finger and is gently guided into the trachea.

Either method requires practice, physicians should try one or both methods on stillborn infants until they become proficient in this procedure. The blind method of introduction has the advantage of not requiring any apparatus and is always available; it has the disadvantage of producing trauma and spasm of vocal cords which can lead to serious obstruction. The direct method would seem to obviate these disadvantages.

After the catheter is introduced, mucus should be removed from the trachea. Then the catheter is attached to the gas tank, and the gas is allowed to flow at 4 to 5 mm. of pressure. This is very important, for if more pressure is used, there is danger of rupturing the alveoli.

Intratracheal catheterization should be used only on the more severely asphyxiated infants who have not responded to the simpler methods of resuscitation. Since this is not an extremely dangerous procedure and because we know the dangers that accompany long periods of anoxia, one should naturally err on the side of too early rather than too late.

Use of Drugs

The so-called respiratory stimulants, alpha-lobeline, metrazol, and coramine, all have enjoyed periods of great use. At the present time many clinicians look with considerable skepticism on the value of these drugs. It is a known fact that many of the apneic babies cry within a short time after birth; in addition, these drugs are very frequently used in conjunction with other methods. This makes it extremely difficult to evaluate which method should be given the credit. In the past it would seem the drugs have been given this credit.

Eastman[6] in a very carefully controlled experiment, produced severe anoxia in a number of dogs. These dogs were then given intravenous injections of alpha-lobeline, metrazol, and coramine, and in none of the instances was Eastman able to detect any effect on the respiration in the presence of anoxia. In fact, severe convulsions occurred in over one-half of the experiments, but they occurred only after complete reoxygenation of the blood. It is the opinion of Eastman and others that the treatment of anoxia at birth consists of supplying enough oxygen rather than the use of stimulating drugs with their likelihood of convulsive actions.

Intracardiac injection of epinephrine has also been used with questionable results; if given, it should only be administered as a last resort for desperate cases. Subcutaneous injections of epinephrine or of any of the other cardiac stimulants should not be used in the treatment of asphyxia, for the impaired cardiac function is due to anoxemia rather than to lack of muscle tone, and whipping the tired muscle does not bring more oxygen unless that vital substance is available.

Mechanical Respirators

While some mechanical respirators, expensive, cumbersome, and complicated devices, are occasionally of use, they certainly are not a necessary part of the armamentarium needed by the general practitioner or the small general hospital.

After-Care of the Asphyxiated Infant

The attacks of recurring cyanosis and respiratory difficulty that occur several hours after delivery are frequently produced by intracranial hemorrhage and less frequently by pulmonary atelectasis. The obstetrician should always keep in mind the frequent association of severe asphyxia neonatorum and intracranial hemorrhage. At times it is very difficult to know if the asphyxia resulted from simple anoxia or if it was produced by intracranial hemorrhage. The problem is still further complicated by the fact that severe anoxia may produce rather extensive petechial hemorrhages in the brain and other vital organs.

It is important in the immediate and particularly in the after-care of the asphyxiated infant for the physician to determine if intracranial hemorrhage is present. The child should be kept warm and should be handled as little as possible. He should be very care-

fully watched so that immediate treatment can be given should cyanotic attacks recur. Often it is advisable to give continuous gas therapy during the first few hours following delivery. It is wise to delay feeding these infants, as their swallowing reflexes are often very feeble, and there is danger of regurgitation and aspiration; this is particularly true in the premature infant. The head of the crib should not be lowered if intracranial damage is suspected.

Prematurity and Asphyxia

In Wisconsin in 1940, 52 per cent of our neonatal deaths occurred under one day. During the last ten years, we have shown a rather substantial reduction in our neonatal deaths. Hunter[7] has noted that this change has been brought about by the reduction of deaths after the first day, while deaths under one day have shown very little change. If we examine the causes of death under one day, we note that in 1940, 62 per cent were caused by prematurity. At once it becomes apparent that a very special problem exists regarding these premature infants.

The obstetrician knows that toxemia, placenta praevia, premature separation of the placenta, multiple birth, syphilis, acute and chronic infections all seem to predispose to prematurity. In addition, prematurity seems unusually prevalent among first-born infants, infants of young mothers, and infants born in rapid succession. Over-work, poor nutritional status of the mother, and endocrine unbalances have been suspected as factors leading to prematurity. All these factors must be kept in mind by the accoucheur, for, if appropriate treatment is given, the period of gestation can be prolonged in certain instances. We know that after the seventh lunar month the fetus will gain 180 to 240 Gm. per week, and during the ninth lunar month from 300 to 360 Gm. per week. In certain of these cases, by special care we should be able to prolong the pregnancy perhaps a week or two and change this baby, with a 90 per cent mortality, into a member of a group which has 50 to 60 per cent mortality, merely by allowing it to become more mature *in utero*.

It is, of course, understood that with such serious maternal complications as a fulminating preeclampsia or placenta praevia, in which the mother's welfare is jeopardized, prompt termination of the pregnancy should be considered. In other words, the physician should recognize these predisposing factors of prematurity and treat them accordingly.

Premature Delivery: A Serious Obstetric Emergency

When premature delivery seems imminent, it should be treated as a serious obstetric emergency. It would be ideal if every premature delivery could occur in a hospital, where facilities are at hand for immediate resuscitation and adequate care of the premature. If the delivery does occur in the home, it should be the duty of the physician to see that a heated crib or incubator and other necessary equipment are provided and ready before the premature infant is born and not several hours later. If this concept were heeded, it would materially aid in the reduction of premature deaths.

The smaller the premature infant, the more immature is the respiratory reflex. When the effects of labor and delivery are combined with a poorly developed respiratory reflex, we see a high incidence of severe asphyxia among our premature infants. If, in addition, the mother is given rather large amounts of analgesic drugs and inhalation anesthesia, this effect is disastrous to a large number of infants. In order to reduce asphyxia among our premature infants, we must restrict the use of analgesic drugs and replace inhalation anesthesia with local infiltration of the perineum.

This whole discussion has been based on the diagnosis of prematurity during the course of labor. It is my opinion that by careful abdominal palpation, coupled with the knowledge of the period of gestation, we can fortell before delivery whether we are dealing with a mature or premature infant in a high percentage of cases.

If we will keep these facts in mind, we can reduce the incidence of asphyxia among our premature infants. Nevertheless, there will still be a large number requiring resuscitation. Stoesser's[7] work at the Minneapolis General Hospital emphasizes the importance

of resuscitation of the premature infant. During a four-year period, 1930 to 1934, in which isolation technic and a definite feeding program were established, the premature mortality dropped from 61 to 33 per cent; during the next four years, 1934–1938, in which special emphasis was placed on resuscitation, the mortality rate dropped from 33 to 19 per cent.

The same general principles of resuscitation apply to the premature infant as to the full-term infant, except that the problem is more urgent and the equipment should always be available when the baby is born. In addition, the premature infant requires more constant supervision and specialized care by nurses trained in premature care.

Since the majority of physicians have only one or two premature deliveries a year, there is a tendency to feel that this is not their problem. On the contrary, these 1 or 2 cases each physician has make up our state totals, and it is the care given these one or two premature infants by each physician that determines the number that survive.

Cesarean Section and Asphyxia

Many surveys of asphyxia neonatorum mention the high incidence of this complication even in purely elective sections. Two causative factors have been frequently mentioned: one is the type and duration of the anesthesia; the other is the lack of compression of the thoracic contents with the drainage of fluid from the bronchial tree. Whatever the cause may be, we should be ever conscious of the fact that these infants often require special care, and everything should be ready that may be needed to resuscitate these babies.

Summary

1. Asphyxia neonatorum is an important factor in the cause of stillbirths and neonatal deaths; equally important is the fact that permanent damage to the central nervous system may occur in some infants that survive.

2. Our every effort should be directed toward the prevention of this complication, which can readily be done.

3. When asphyxia does occur, resuscitation is not a complicated procedure requiring special apparatus or training. The majority of infants can be resuscitated by keeping them warm, clearing the air passages, supplying oxygen, and handling them gently.

4. Infants born prematurely and those delivered by cesarean section often need special attention.

BIBLIOGRAPHY

1. Kosmak, G. W.: Obstetric Training of Nurses and Attendants, Am. J. Obst. & Gynec. 21:828 (June) 1931.
2. Schreiber, F.: Apnea of the Newborn and Associated Cerebral Injury; Clinical and Statistical Study, J.A.M.A. 111:1263 (Oct. 1) 1938.
3. Lund, C. J.: The Recognition and Treatment of Fetal Heart Arrhythmias due to Anoxia, Am. J. Obst. & Gynec. 40:946 (Dec.) 1940.
4. Lund, C. J.: Prevention of Aspnyxia Neonatorium, Am. J. Obst. & Gynec. 41:934 (June) 1941.
5. Waters, R. M., and Harris, J. W.: Carbon Dioxid and Oxygen Problems in Obstetric Anesthesia, Anesth. & Analg. 10:59 (Mar.–Apr.) 1931.
6. Eastman, N. J., and Kreiselman, J.: Treatment of Experimental Anoxia with Certain Respiratory and Cardiac Stimulants, Am. J. Obst. & Gynec. 41:260 (Feb.) 1941.
7. Hunter, Amy L.: Personal communication.
8. Stoesser, A. V.: Reducing Premature Infant Mortality with Special Emphasis on Resuscitation, Journal–Lancet 59:236 (May) 1939.

RESTRICTIONS ON ANTI-FREEZE LIFTED

The so-called "permanent types" of anti-freeze became available for use in passenger automobiles throughout the nation beginning October 1 through an amendment to Limitation Order L-51 issued recently by the War Production Board.

A previous amendment to the order on April 19 had the effect of restricting anti-freeze made from or containing ethylene glycol to commercial vehicles, buses, trucks, tractors and stationary engines, and pursuit cars of state police departments.

Release of "permanent types" of anti-freeze for use in passenger cars does not mean that there has been any increase in the amount available, the Chemicals Division of WPB said, but merely is carrying out a policy of allowing first call on existing supplies for the heavier vehicles in which evaporation from overheating is a consideration. Since owners and operators of the heavier vehicles had an opportunity to acquire necessary amounts by October 1, the remaining supplies became available for passenger car use on and after that date.

The Treatment of Burns

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THE treatment of burns seems to be reverting to practices which were common in the seventeenth century when bland ointments were the accepted method. Pressure dressings were also common in the treatment of amputation stumps which had been cauterized by fire or boiling oil. Modern treatment can boast no more except for refinements in details and technic. The greatest advances have been made in systemic treatment of the severely burned patient.

The problem of burns resolves itself into the following: first, the treatment of shock; second, the treatment of the local lesion; and, third, restoration of function whether the burn occurs in industry, in warfare, or in civil life. Any adequate treatment must be directed toward one or all of these three factors.

Shock: The Primary Consideration

Shock must be the primary consideration, because, if improperly or insufficiently treated, the patient may succumb before any local treatment can be started. We must revise some of the older concepts of the treatment of shock. All of us remember the classically described rest, heat, and fluids so often repeated in texts and lectures. There is no argument as to the importance of rest in shock. Whether rest is obtained by means of opiates or barbiturates makes little difference. One caution is suggested: most burned patients in shock are oversedated. Morphine in doses greater than 0.25 grain are rarely necessary. Any restlessness or delirium following such a dose is very likely not due to pain but probably to cerebral edema or anoxia. This was strongly suggested in some of the patients in the Cocoanut Grove disaster.[1]

Some doubt has been cast upon the application of heat in shock. Supplying excessive amounts of heat does not seem to be necessary. Experimental animals survive longer when no heat is applied. Blalock[2, 3] has shown that heat may cause a peripheral vasodilatation which, in turn, may result in a diminution of blood volume circulating through vital areas and will thus increase the shock symptoms instead of decreasing them. We now keep our "shock tents" for burns at, or slightly below, body temperature.

The Administration of Fluid

The administration of fluid is most important and must be accomplished as early as possible. Saline and glucose solutions are not satisfactory as they do not remain in the circulation long enough to influence materially the shock symptoms. Stimulating drugs or vasoconstricting substances have little to recommend them. Some colloidal solution administered intravenously is a necessity. Human blood is tne most perfect solution. However, as there is usually some hemoconcentration in burn shock, serum or plasma is the most logical. Pooled plasma is generally available now in most cities, and dried plasma or serum is commercially available for all.

There is a tendency to give increasing amounts of plasma. Harkins[4] has suggested giving 500 cc. of plasma for each 10 per cent of the body surface involved by the burn. Presman and others[5] suggest immediate administration of 60 cc. of plasma for

every per cent of the body surface burned, 20 to 30 cc. for every per cent during the first twenty-four hours, and another 20 to 30 cc. in the next forty-eight hours following the burn. Harkins,[4] Black,[6] and Elkinton, Wolff and Lee[7] have laboratory methods for calculating the plasma dose, but they give much smaller doses than Presman and his associates.[5] The lower doses seem to be adequate for mild shock, but for severe shock in extensive burns, the higher dose may be advisable. The administration of plasma is necessary for at least three days after the burn. There is some question as to whether or not adrenal cortical extract might shorten the period of shock by decreasing the capillary permeability, but there are no clear-cut clinical observations to confirm laboratory experiments. We use it in severe burns but have yet to see any clinically demonstrable effect. Crystalloid solutions should be used only to supply fluid requirements and not to combat shock.

The method of Berkow[8] is used in the calculation of the percentage of body surface involved. This calculation can be made from the following table:

Region	Per Cent of Body Surface Involved
Head	6
Upper Extremities:	
Both arms and forearms	13.5
Both hands	4.5
Total	18
Trunk:	
Anterior surface	20
Posterior surface	18
Total	38
Lower Extremities:	
Both thighs	19
Both legs	13.6
Both feet	6.3
Total	38.9

Simple Treatments More Effective

The multitude of treatments for the local burned area is proof of the fact that none is ideal. A burn is merely a large, open wound, and the principles of treatment for one apply to the other. Cleanliness of the wound is essential. Most severe burns are quite sterile if the patients are admitted to the hospital early. After a few hours, all sorts of organisms can be cultured from the burned surface. We still feel that a superficial débridement and thorough cleansing with soap and water prevent massive contamination in most cases. All of the cases from the Cocoanut Grove fire treated at the Massachusetts General Hospital were not cleansed or excised, and the results were very satisfactory. There are many things to be said in favor of this practice, and, in a disaster of such magnitude, it is certainly desirable. In a recent survey of small industrial burns, McClure and Lam[9] advise washing the burn with white soap and water without débridement and then covering the wound with fine mesh gauze impregnated with petrolatum or 5 per cent boric acid ointment and, finally, covering this with a firm dressing.

Coagulating methods have lost popularity because they do not accomplish their purpose as well as more simple treatments. They do not prevent loss of plasma from the capillary bed, as this is not only a local phenomenon. They do not prevent infection unless the wound was clean when the coagulant was applied. Epithelialization is inhibited. There is evidence that tannic acid causes damage to the liver. The sulfadiazine spray of Pickrell has an additional disadvantage in that there is absorption of the sulfadiazine which may exceed the toxic limit of the drug in the blood stream.

The application of Bunyan envelopes over burned extremities, especially in late stages of the burn, has gained popularity in England and seems to have given satisfactory results. This is merely a modification of the continuous bath method used in many parts of this country.

Pressure Dressings

The method of pressure dressings popularized by Koch has gained increasing favor in this country for several reasons. If applied early, such a dressing definitely reduces the likelihood of shock. This has been shown by the experiments of Bywaters and Popjak[10] in England and Duncan and Blalock[11] in this country. The pressure reduces the ex-

travasation of fluid into the tissues, prevents excessive granulation tissue, and keeps the area clean. Avoiding wrinkles, the physician places fine mesh gauze (40 x 44 mesh) usually impregnated with petrolatum, aquaphor, or scarlet red ointment directly over the cleansed wound. Washed, fluffed gauze is placed over this and then sea sponges or mechanic's waste in a fairly thick layer. An elastic bandage is then applied with firm pressure. These dressings are changed every five to ten days with sterile precautions.

Tetanus antitoxin is administered to all cases when contamination is at all likely. One of the sulfanilamide compounds is usually administered for about one week. Penicillin has not been very extensively used, but, from reports, it holds great promise in the treatment of large, infected, granulating wounds.

Restoration of Function

The restoration of function should begin just as soon as the danger of shock is over. Uninvolved areas of the body should be exercised. There is not much point in attempting to prevent contractures by mechanical methods in the involved portions until they are covered by epithelium. The areas not epithelialized within two weeks should be skin-grafted. Some areas of third degree burns cannot be prepared for grafts in two weeks, but as soon as all slough has disappeared and infection is minimal, skin grafting should be attempted. The type of graft must be judged in the individual case, not only from the standpoint of the depth of the burn and the area to be covered but also by the experience of the operator. As a general rule, thin grafts of the Thiersch or split-skin type are the most satisfactory. In moderately infected areas which cannot be made clean enough for this type of graft, a Davis or pinch-type of graft may be used. In areas which must withstand trauma, full-thickness grafts are usually advisable. In certain types of cases, when the burn is obtained after having been infected for a long time, it is sometimes advisable to allow spontaneous healing to take place and then treat the contractures by plastic procedures later.

The treatment of burns requires patience, ingenuity, and the evaluation of details of procedure necessary to overcome the systemic disturbances and to effect epithelialization in the shortest possible time with the least disturbance of normal function.

BIBLIOGRAPHY

1. Members of the Staff, Massachusetts General Hospital: Management of the Cocoanut Grove Burns, Philadelphia, J. B. Lippincott Co., 1943.
2. Blalock, A., and Mason, M. F.: A Comparison of the Effects of Heat and Those of Cold in the Prevention and Treatment of Shock, Arch. Surg. 42:1054 (June) 1941.
3. Blalock, A.: A Comparison of the Effects of the Local Application of Heat and of Cold in the Prevention and Treatment of Experimental Traumatic Shock, Surgery 11:356 (Mar.) 1942.
4. Harkins, H. N.: The Treatment of Burns, Springfield, Illinois, Charles C. Thomas, 1942.
5. Presman, D. L., and others: Intensive Human Serum Treatment of Burn Shock, J.A.M.A. 122:924 (July 31) 1943.
6. Black, D. A. K.: Treatment of Burn Shock with Plasma and Serum, Brit. M. J., p. 693 (Nov. 23) 1940.
7. Elkinton, J. R.; Wolff, W. A., and Lee, W. E.: Plasma Transfusion in the Treatment of the Fluid Shift in Severe Burns, Ann. Surg. 112:150 (July) 1940.
8. Berkow, S. G.: A Method of Estimating the Extensiveness of Lesions (Burns & Scalds) Based on Surface Area Proportions, Arch. Surg. 8:138 (Jan.) 1924.
9. McClure, R. D., and Lam, C. R.: A Statistical Study of Minor Industrial Burns, J.A.M.A. 122:909 (July 31) 1943.
10. Bywaters, E. G. L., and Popjak, G.: Experimental Crushing Injury; Peripheral Circulatory Collapse and Other Effects of Muscle Necrosis in Rabbit, Surg., Gynec. & Obst. 75:612 (Nov.) 1942.
11. Duncan, G. W., and Blalock, A.: The Uniform Production of Experimental Shock by Crush Injury: Possible Relationship to Clinical Crush Syndrome, Ann. Surg. 115:684 (Apr.) 1942.

Wisconsin has the lowest death rate from tuberculosis among all states of 3,000,000 population. Wisconsin and Michigan have the highest ratio of sanatorium beds to deaths among these states. *Crusader,* Sept. 1943.

COMMENTS ON TREATMENT

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The Sulfonamides ("Sulfa Drugs")

Clinical Indications

Sulfanilamide:

(1) Infections due to beta-hemolytic Streptococcus (A group).
(2) Erysipelas.
(3) Meningococcal infections.
(4) Gonococcal infections.
(5) Urinary tract infections due to Escherichia coli, Aerobacter aerogenes, Salmonella, Shigella, Staphylococcus albus, Staphylcoccus aureus and Proteus vulgaris. (Ineffective against Streptococcus fecalis.)
(6) Bacillus welchii.
(7) Ducrey's bacillary infection.

Sulfapyridine:

(1)–(7) Infections listed above.
(8) Pneumococcal infections.

Sulfathiazole; Sulfadiazine; Sulfamethazine; Sulfamerizine:

(1)–(8) Infections listed above.
(9) Staphylococcal infections.
(10) Escherichia coli bacteremia.

Sulfaguanidine:

This drug is unique in that it is very readily excreted by the kidneys. Its special promise is in infections in the gastrointestinal tract, particularly, in bacillary dysentery; however, it is not effective in typhoid.

Sulfasuxidine (Succinylsulfathiazole):

This drug is readily absorbed and excreted. Its action is similar to that of sulfaguanidine but appears to be less toxic. Apparently, sulfathiazole is liberated from the succinic acid complex in the colon, from which site it is but slightly absorbed. Because of this slight absorption, local concentration and action on susceptible bacteria, such as in bacillary dysentery, is high. That which is absorbed from other parts of the intestine appears to be relatively nontoxic and ineffective since it is already "succinlylated." (This is analogous to acetylation.)

Promin:

This drug is apparently the therapeutic and toxicologic equivalent to sulfanilamide but is water-soluble and produces less nausea and vomiting. It is of some promise in tuberculosis, especially in the early stages.

Solubility[1, 2]

Solubility in water or in urine, 37 C., mg. per 100 cc.

Drug	pH 5.5	pH 6	pH 6.5	pH 7	pH 7.5
Sulfapyridine	61.		61.3		61.8
Acetyl sulfapyridine	32.6		34.1		36.5
Sulfathiazole	95.		103.		192.
Acetyl sulfathiazole	5.8		6.		25.1
Sulfadiazine	18.		20.		51.5
Acetyl sulfadiazine	25.5		43.		248.
Sulfamethazine	191.		209.		297.
Acetyl sulfamethazine	115.		117.		176.
Sulfamerizine		60.	75.	120.	500.+
Acetyl sulfamerizine		120.	180.	320.	500.+

The solubility of the first eight drugs listed was determined in water (reference 2), whereas the solubility of the last two drugs was determined in urine (reference 1).

Owing to differences in the solvents used in the foregoing table, it is impossible to compare accurately the solubility of sulfamerizine and sulfamethazine to that of other sulfonamides on the basis of available data.

Toxicity Reactions

(1) Cyanosis; acidosis.
(2) Headache, nausea, and vomiting.
(3) Skin eruptions; apparent sensitivity to sunlight.
(4) Methemoglobinemia.
(5) Acute hemolytic anemia.
(6) Granulocytopenia.
(7) Optic neuritis.
(8) Peripheral neuritis.

(9) Renal damage due to precipitation of the relatively insoluble acetylated sulfonamides. (See the table of relative solubilities.)

(10) Drug fever.

(11) In nephritis, anticipate accumulation of drugs in the body.

(12) In virus diseases, sulfonamides are ineffective other than to control secondary infections.

Little new has developed in regard to toxicity except to affirm that in susceptible cases or in overdosages, some methemoglobin is actually formed; also, unidentified blood pigments appear. There is no clear evidence that sulfates predispose the blood to sulfhemoglobin formation.

General Comments

Sulfapyridine is somewhat more slowly absorbed from the gastrointestinal tract than sulfanilamide and, therefore, is thought to be less toxic than the latter. Studies of blood concentration of each of the two drugs demonstrate that at equal concentrations in the blood, sulfapyridine is more toxic than sulfanilamide. Both sulfanilamide and sulfapyridine have been replaced largely by sulfathiazole or sulfadiazine.

Sulfathiazole is somewhat more rapidly absorbed and excreted and less acetylated than sulfapyridine but less rapidly absorbed than sulfadiazine. Either may produce renal obstruction. This agent is cheaper than sulfadiazine and its derivatives.

Sulfamethazine and sulfamerizine are quite new (1942–43) but, as can be seen from the table of solubilities, appear less likely to produce plugging of urinary tubules than other sulfonamides. Their effectiveness is much like that of sulfadiazine and sulfathiazole.

The strongly alkaline sodium salts of sulfapyridine and sulfathiazole are available for parenteral administration, but their high alkalinity makes subcutaneous or intramuscular injections generally undesirable.

In general, 1,000 to 1,200 cc. of water should be administered daily to reduce liability from acetylated sulfonamides crystallizing in uriniferous tubules. Sodium bicarbonate to render the urine neutral or slightly alkaline may be advisable. (See the table of solubilities.)

Dosage

The evidence to date tends to indicate that the optimal results are obtainable with a blood concentration of the drugs ranging from 4 to 12 mg. per 100 cc. It does not follow that better results are obtained with the higher blood levels than with the lower. (See the following comments on mechanism.) Care *must* be taken with respect to renal function, since oliguria is likely to effect a rising blood level of the drugs as well as to predispose greatly to deposition of crystals within the uriniferous tubules.

Mechanism of Action

These agents are primarily bacteriostatic in vivo. In vitro, they are bactericidal only at elevated temperatures and in the absence of peptones. Phagocytosis is not stimulated directly by the drugs. It appears, therefore, that while these drugs do not readily kill bacteria in vivo, they injure or otherwise affect them so that defensive processes of the body can operate more effectively. Peptones, pus, and necrotic tissue appear to contain para-aminobenzoic acid or substances similar to it. Since this substance has a very great capacity for blocking the action of sulfonamides, it is evident that these drugs cannot be expected to be effective in the presence of pus or necrotic tissue.

In all instances of drug therapy or chemotherapy, three cardinal points must be considered: (1) the host or patient; (2) the infecting or causative agent or factor; (3) the drug or chemical. Each may act upon, or modify, the other two. Since drugs should be considered as chemical splints or aids to the defense processes in the body, some failures are inevitable owing to the fact that the defenses of certain individuals are inadequate even when the usually effective concentrations of chemotherapeutic agents are present.

Finally, "drug fastness," or tolerance of bacteria to sulfonamides, has been demonstrated both in vivo and in vitro. This fact should be kept in mind lest inadequate therapy let loose a drug-resistant strain. Also, there is a growing amount of evidence, even though small as yet, that instances of acquired sensitivity of patients to sulfonamides

may be expected with the result that when a patient really needs these agents he may have become sensitized by a previous and perhaps unnecessary course of exposure.
A. L. T.

BIBLIOGRAPHY

1. Welch, A. D., and others: Sulfamerizine (2—Sulfanilamido—4—Methylpyrimidine), J. Pharmacol. & Exper. Therap. 77:357 (April) 1943.
2. Macartney, D. W., and others: Sulphamethazine: Clinical Trial of a New Sulphonamide, Lancet 1:639 (May 30) 1942.

Hernias Under Workmen's Compensation

By MR. HARRY A. NELSON
Madison

MR. H. A. NELSON

Mr. Nelson is director, Workmen's Compensation Division, Industrial Commission of the State of Wisconsin

HERNIA has been said to be the greatest frailty of the American worker. It is stated that one man out of ten in the United States suffers from hernia, and a higher proportion are potential subjects for hernia.

To physicians as well as to students of social legislation the treatment of hernia under workmen's compensation acts is of interest. It illustrates a compromise between schools of thought and public policy,—medical, legal, political and humanitarian.

In this article, an attempt is made to appraise the legal principles which have been evolved under the Wisconsin workmen's compensation act for the compensating of claims founded upon hernia alleged to have resulted from employment. Properly, no attempt is made to explore the technical, medical and surgical features of hernia, which are peculiarly the province of physicians and surgeons.

Industry and Humanitarian Legislation

It is a striking development that industry, since the turn of the century, has shown an increasingly liberal and humane attitude toward the rights of the working men. Employers themselves have been instrumental in initiating humanitarian legislation and in assuming a measure of moral as well as strictly legal responsibility for injuries incurred in the course of employment and in resolving reasonable doubts in favor of, rather than against, employes who claimed industrial injury. Sometimes insurance carriers and servicing agencies lose sight of that fact and with over zeal in desire for profit or competitive advantage, and with the avowed intent of "protecting the employer's interests," accomplish exactly the opposite result by assuming hypertechnical positions, neither desired nor approved by the great majority of employers. The "company" doctor attitude of favoring stringent legal rights of an employer as opposed to moral rights of employes has largely disappeared. Many employers believe that the newer approach correctly expresses desirable industrial and social justice and good business sense and gives proper impetus to the new humane influence which has pervaded industry as contrasted with the laissez-faire practices of the 90's. Legislatures and commissions have quite naturally adopted laws, rules, and interpretations reflecting this attitude. These are often at variance with decisions rendered by courts in precompensation days. With this attitude has come the commendable practice of physical examinations by employers with a view to discovering existing defects and of placement of employes in positions suitable to their physical condition.

Differing Views as to Causes of Hernia

The layman's popular conception as to the cause of hernia differs widely from the scientific explanation given by anatomists

and surgeons. For this reason, much controversy arises as to hernia claims under workmen's compensation acts. Employes quite honestly believe that hernias usually result from effort and incidents related to work, while medical men conclude that although these factors may play a part in producing hernia, many other factors dissociated from work may in numerous cases play a more important part. Physicians, moreover, do not always agree among themselves as to the part played by effort of work or accident as compared with other causal factors. Labor organizations sometimes complain that commission holdings are prejudicial to employes, and employers and insurance carriers sometimes consider them over liberal in the light of asserted scientific theories.

Workmen's compensation legislation has, by and large, been evolved as a compromise between the views of labor and capital. Political and scientific considerations have played their parts in the final result. As a consequence, rules vary from state to state, —from liberal to strict criteria—for determination as to liability for industrial injury.

After considering thousands of hernia cases over many years, the Wisconsin Industrial Commission has been able to crystallize certain postulates as representing the consensus of medical opinion as to causation of inguinal hernias. The underlying rules as to causation have been construed to apply with equal force to practically all types of hernia.

Almost invariably a preexisting weakness or anomaly of body structure exists, without which the hernial protrusion would not occur. Because of the preexisting condition, hernia may result at any time without assignable cause other than the preexisting condition or the force of gravity pulling down on abdominal contents, or motion or effort which forces or enables bodily content to enter at the point of weakness or abnormality and to emerge as a hernial protrusion.

Was the Protrusion Caused By Conditions of Employment?

And here comes the bone of contention. Was the protrusion caused by one or more efforts necessitated by the employe's work, or did it come "spontaneously"? How much violence or force is necessary to produce protrusion? If the protrusion manifests itself after a lift, or slip, or effort, the employe often naturally concludes that the old axiom, "after which, therefore because of which," is the most logical explanation for the condition. Actually the incident assigned as cause may play an infinitesimal or no part in producing the unwelcome protrusion and some weeks of disability and expense for medical and hospital treatment.

We recognize, however, that work may play an important role in producing the final result. Failure of physicians to recognize the correct legal rule often actuates testimony that hernia did not result from work, the testimony being based on the erroneous legal conception that because the employment did not cause the preexistent condition, it should not be held liable for the ultimate result, even though the final culmination is produced by violence or effort of work. The usual testimony of physicians is that intra-abdominal pressure is one of the inducing causes for the hernial protrusion. Such pressure tends to push out or down on the viscera and their enveloping membranes and finally to cause their extrusion into the opening already prepared for their reception, or by gradual enlargement of the opening to permit the hernia to appear. Intra-abdominal pressure is caused by gravity (man walks in an upright position, one of the regrettable results of which is the tendency of the abdominal organs to follow the Newtonian law and to seek a lower level, producing the pot belly so common among middle-aged and older persons) or by effort in lifting, pulling, pushing, catching one's self in slipping or falling, blows on the abdomen, coughing, straining at stool, and by other elements of effort.

Determination of Cause

Hard work, necessitating lifting of heavy objects, or other effort causing intra-abdominal pressure, may, therefore, be a producing factor in the final result. But ordinary activities of life, further weakening of abdominal walls by malnutrition, age, or other cause, such as coughing and straining at stool, may play an important or a more important role. To warrant an award for com-

pensation, it is the commission's obligation to find in effect that but for the work hernia would not have appeared at the time it did. It will be appreciated that that is no easy task in many cases. However, the measure of proof in workmen's compensation is a preponderance of probabilities, not proof beyond reasonable doubt. If the commission can say that in reasonable probability the work was of a type and of duration entailing efforts such as to produce intra-abdominal pressure sufficient to cause hernial protrusion, and that other causes alone would not have produced the end result at the time of its occurrence, a good case is made out. If it is shown that efforts away from work, or coughing or straining at stool probably are to blame, the case remains speculative and must be disallowed. The fact of a preexisting condition does not militate against liability; indeed, without the preexisting condition, few cases could be established. If the work generally is of a light character and not such as to produce substantial intra-abdominal pressure, industrial hernia cannot be established except under the theory of accident. If work is of a heavy character over some duration of time, such as lifting of heavy objects, and extraneous effort can be excluded, a good case is made. Probably in the case of one who has done light work for some time and then does heavy work, a shorter period of time may be recognized as sufficient. One of slight build who must use greater effort to accomplish his work may incur greater intra-abdominal pressure and, therefore, develop hernia sooner than one of sturdy physique who handles his work more easily. Parenthetically, much can be done to obviate intra-abdominal pressure by lifting properly by use of the legs, thus avoiding straining of the abdominal muscles.

Is the Last Impulse Responsible?

At times it is contended by claimants that if the last lift, large or small, is followed by protrusion, liability should be found under the rule that no matter what the preexisting condition, the industry becomes responsible for the final result provided industry supplies the "injury" which produces that result. But how can anyone know that a single impulse actually did occasion the final protrusion? Thousands of impulses may have contributed over long periods of time. The last impulse may have been produced by a mere turn or twist or other ordinary activity, either in or out of work, not of sufficient severity to designate it as an "injury," or to remove doubt as to whether the movement accelerated the final result. If enough impulses of sufficient severity are caused by work to remove ultimate cause from the realm of speculation, industry can and should be charged with the final result. The Supreme Court has said in the case of Marathon Paper Mills v. Industrial Commission, 203 Wis. 17, "It appears that there is such a thing as occupational hernia, that the work followed by the applicant during a long series of years was such as was calculated to give rise to such a result," and that, "If the occupation be one which naturally gives rise to a disease, then the disease acquired by reason of the occupation followed may properly be said to be an occupational disease, even though it might result from more than one occupation."

"Traumatic" Hernia

What of the so-called "traumatic" hernia? Some physicians contend that there is no such thing except as the body wall may actually be cut or torn, allowing internal contents to escape. The answer to the question is largely one of the definition of trauma. Do we mean direct violence from without? If we use the word "accident," we are on more tenable ground. An accidental hernia need not necessarily be traumatic in the more narrow use of the latter term. The word "rupture" as a synonym for hernia is perhaps unfortunate, as it connotes an actual violent tearing of tissues. Again, if we speak only of the whole process culminating in protrusion,—the congenital condition, the gradual process, and the final result,—obviously the hernia is very rarely traumatic in the sense of being caused by a single, direct act of violence. If we focus on final protrusion or strangulation of an existent hernia, disregarding cause of the previous condition and progress, many physicians will concede that the ultimate result may come by accidental means, fixable as to time and place. As Dr. Mock has stated in his very able

chapter on compensable hernia in his book "Industrial Medicine and Surgery," "The surgeon who recognized the preexisting congenital defect or the preformed sac and yet testified that the accident must have been a contributing factor in the final development of the hernia was not unscientific or unorthodox." But to remove the final "accidental" causative factor from the field of conjecture, it must be shown to be adequate. It must produce enough intra-abdominal pressure at a given moment to cause the result for which compensation is claimed,—not the whole condition but the ultimate result, that is, the actual protrusion which necessitates treatment or causes disability. So a slight lift or slip is not sufficient to cause the result.

Standards of Proof of "Accidental" Hernia

After some years of experience and study, the Wisconsin Industrial Commission concluded that if a hernia were to be designated as "accidental," certain minimal standards of proof logically should be met. Hearing of testimony and study of authoritative literature convinced the commission that if a single incident were to be assigned as causing the final result, it would have to be such as *could* produce the result, that the hernia appeared immediately after the accident, that it was followed by pain immediately disabling the claimant, and that the claimant gave immediate notice of injury to the employer. The first requirement is obviously correct. If the hernia becomes apparent after little or no effort, the single incident relied upon did not cause the result. Unless the hernia appeared soon after the accident, it is very questionable that the single incident actually caused the final result. If enough of the progress can be assigned to a single incident, considerable pain should ensue, enough to cause at least some disability almost at once, although disability need not be continuous or unduly protracted. If such a serious occurrence has taken place, the employe should and will report to the employer with reasonable haste. These are reasonable rules and rules of practical expediency. It is conceivable that a rare individual can withstand pain to such a point that he will continue work after an accident producing hernia, but that is not the general experience, and a general rule having been found desirable and practically imperative must consider the conduct of "average" normal human beings. Failure of the employe to conform with such conduct throws further doubt upon a subject already fraught with some doubt and confusion and thus puts the claim in the realm of speculation.

The court found the commission's rules proper and approved them in the case of Meade v. Wisconsin Motor Mfg. Co., 168 Wis. 250. It stated:

> "The commission assumes from common knowledge that inguinal hernia is rarely caused by accident, but is generally the result of inherited or acquired weakness. These facts concerning the cause of hernia seem to be so generally known and undoubted that no proof of them is required. The proceedings in compensation cases sustain the conclusion that this assumption is correct."

In conclusion, we believe that much of the confusion as to liability in hernia cases comes because of the failure to understand that injury may be compensable if it results in disability, even though the final result could not have occurred but for a preexisting condition developed perhaps over years and operating on a congenital weakness or abnormality. Hernias usually come gradually and may be compensated on the basis of gradual causation by work necessitating arduous effort. They may also be found to come by accident, provided the circumstances surrounding the alleged accident are such as to corroborate the result as accidental. Employes fail to take a scientific view and want hernias compensated even though it is speculative to assign even aggravation or acceleration to employment. Some other persons feel that responsibility should not be charged against employment unless the entire condition can be ascribed to the employe's work, contrary to legal principles even in common law cases. Adherence to this position would exclude liability in essentially all hernia cases. Wisconsin, as have many other states, has adopted a middle course, which has done much to resolve a problem frequently cited as the most troublesome one under workmen's compensation administration.

The Nation at War

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

R. W. BLUMENTHAL

Dr. Robert W. Blumenthal, Milwaukee, was appointed to the state council of defense by Governor Walter S. Goodland on September 17.

The appointment fills the vacancy created when George R. Howitt became director of the council after the death of John Cudahy. Dr. Blumenthal's selection is subject to confirmation by the state senate when it convenes in January.

Dr. Blumenthal was born at Columbus, Wisconsin, in 1881. He graduated from the University of Illinois College of Medicine in 1904 and was licensed to practice medicine and surgery in Wisconsin in 1905. In 1925 he was president of the Medical Society of Milwaukee County and served as chairman of the Medical Advisory Committee for Relief three and one-half years. He is editor of the *Milwaukee Medical Times,* has served several terms on the Council of the State Medical Society and was re-elected to that body at the last session of the House of Delegates of the Society.

In addition to being a member of the Medical Society of Milwaukee County and the State Medical Society of Wisconsin, he is also a member of the Milwaukee Society of Internal Medicine, the American Medical Association, and a Fellow of the American College of Physicians.

In 1938, Dr. Blumenthal served as a member of the Special Committee to Study the Distribution of Health Services and Sickness Care, of the State Medical Society, and collaborated in its report.

During World War I, he served overseas with the Thirty-Second Division and held the rank of major. He also served with the National Guard at the Mexican Border. Major Blumenthal trained at Fort Riley, Kansas, and Waco, Texas, before sailing with the Thirty-Second Division. Later, he became assistant division surgeon of the same division, subsequently being removed from that post to become assistant chief surgeon of the First American Field Army of over 1,000,000 men.

Military Notes

Lieutenant Adrian W. Frankow, 33, West Bend, died Tuesday, August 10, at the Mayo Clinic, Rochester, Minnesota. He had been ill since February 20, 1943, with complications from an illness acquired while in the Army.

He was born at Green Bay on August 16, 1909. He was graduated from the Marquette University School of Medicine in 1933 and interned at the Evangelical Deaconess Hospital, Milwaukee, in 1934, after which he became associated professionally with his brother, Dr. Raymond Frankow, in West Bend.

Dr. Frankow enlisted in the medical corps in January, 1942, and was commissioned a first lieutenant. Fort George Wright, Washington, was his first assignment, which he began in June, 1942. Later he was transferred to Ephrada, Washington, where he was in charge of the surgical staff. Promoted to flight surgeon, he was transferred to Randolph Field, Texas, for basic training and was graduated with honors. From there he was sent to the Santa Ana Air Base in California, then to Salt Lake City, Utah, and finally to Biggs Field, El Paso, Texas, after having been assigned to the 389th Bombing Group.

About the time he was to be assigned to overseas duty, he became ill and was confined to the William Beaumont General Hospital, El Paso, Texas. In May, 1943, he was placed on inactive duty until such time as his recovery could be effected.

Dr. Frankow is survived by his widow, his parents, and one brother.

"Dr. Russell Jackson, Jr., [Madison], who has been in town this week after a year on a destroyer which took part, among other things, in the Sicilian invasion, didn't do much talking when a Journal reporter interviewed him, but if you talk with some of his friends with whom he talked while he was here, you'll hear many amusing and interesting side-lights on the life of a medical officer in the navy.

"There is the officers' dance to which he went in Oran one night, for instance. It was held at the Red Cross club and as the officers began to gather they could see (or hear, rather) that the orchestra, of about 30 pieces, was simply superb.

" 'Many of the musicians had been members of big name bands before they went in the army,' Dr. Jackson said, 'and I've never heard better music anywhere.'

" 'But—' he added woefully—'when all the officers had gathered there were between 250 and 300 of them, and there were only FOUR army nurses for them to dance with. Every other available girl had been called on duty.'

"It was also in Oran that the great friendliness of the Germans to Americans was noted, he said. If the crew of a German ship thought they were being captured by any of the other Allies, they promptly and obviously threw all of their valuables, even watches, into the water. If they thought the captors were Americans, however, they saved them and either gave them to the Americans or traded them for cigarettes and such.

"Then there was the matter of the autographed photographs of the beautiful chorus girls. Once when his ship was in port in New York, Dr. Jackson said, the officers gave a party at the Officers' club and among the guests were all of the famously beautiful chorus girls from the night club Versailles.

"Most of the officers exacted promises from the various girls to send them autographed photographs, but since Mrs. Jackson was also present at the party, Dr. Jackson didn't have a chance. Later, then, when they would get mail at various ports and first this brother-officer and then that would get an autographed picture of a luscious beauty to hang in his cabin, he was slightly irked.

"The next time he was in New York, then, he went to see the equally-beautiful and famous Rockettes chorus and had a brilliant idea! After the show he went to the stage door, button-holed a beauty as she left the theater, told her his sad story, and exacted a promise from her to send him a photograph of the entire chorus . . . 40 girls as beautiful as those at Versailles . . . autographed to him by each of them. And she kept her promise—which was why Dr. Jackson was later the envy of all the other officers on board his ship.

"Most warriors coming home have numerous tales to tell of meeting their favorite first cousin in the middle of the Sahara, or their college roommate in the next bunk . . . but not Dr. Jackson. HIS 18 months in the navy has been marked by a conspicuous absence of any such reunions. When he was at the naval base at San Diego, he met one man whom he had known vaguely at college, but that was all.

"After he had been at sea, on the same ship, for almost a year, however, he happened to be talking with a yeoman in the crew who had also been on the ship all that time, and they began to talk about trout fishing. That led to Wisconsin, of course, and THAT disclosed the fact that Dr. Jackson was from Madison.

" 'Gee . . . I've an aunt who's a doctor in Madison,' the sailor said. 'Maybe you know her . . . her name is Dr. A. M. Schwittay.'

"And Dr. Jackson did, of course, since Dr. Schwittay and he are both members of the Jackson clinic staff.

"The story of Dr. Jackson's which we like best, however, is the one about how he first learned his expected baby had arrived and was a girl.

SUSAN JACKSON

"As has been told before, Mrs. Jackson's letter telling him that Susan was born early in July missed him and when his ship was pulling into the New York harbor he still didn't know what was what.

"Before the rest of them left the ship, the communications officer, among a few others, went ashore first and his wife, a friend of the Jacksons, told him about Susan, the new baby.

"When the destroyer, pulled slowly along by a tug but still too far away for shouting, approached the dock, then Dr. Jackson saw the communications officer standing there making motions to him.

"The communications officer first cradled his arms and rocked them as though he was holding a baby and smiled broadly . . . so that Dr. Jackson knew the baby had arrived.

"Then the communications officer motioned his arms and hands out and down along the sides of his legs toward his knees, and then drew an imaginary line with his finger just below his knees . . . outlining a skirt . . . and Dr. Jackson knew his new baby was a girl.

"And since they didn't have any pre-arranged signals, we think this is the most ingenuous bit of communications we've heard during this war." From "Madison Day by Day" in the August 13, 1943, issue of *The Wisconsin State Journal.*

S. A. FREITAG

Captain Samuel A. Freitag, who has been associated with the Pember-Nuzum Clinic at Janesville since 1931, is now in indoctrinate training at Carlisle Barracks, Pennsylvania, where he reported on August 26 after being commissioned a short time earlier. Upon completion of this training, he will be assigned to Fort Benjamin Harrison, Indianapolis, Ind.

A graduate of the University of Wisconsin Medical School, Madison, and Rush Medical College, Chicago, he was a resident physician at Cook County Hospital, Chicago, before locating at Janesville. As a native of New Glarus and an authority on the Swiss settlement, he has spoken over station WCLO for the Daughters of the American Revolution radio series.

G. B. BENSON

Captain George B. Benson, Richland Center, is at present stationed somewhere in North Africa, where he has become acquainted with Colonel Otis Benson of Minnesota. In addition to the same last names, the two men were born on the same day in the same year, their mothers were school teachers, and their fathers physicians who had attended Rush Medical College. In addition, the two young officers both served interneships at the Presbyterian Hospital, Chicago, both went to the same medical college, and both are now flight surgeons with the United States expeditionary forces. Yet they never met until both went to Africa.

Captain Benson, who entered service February 10, 1941, was first assigned to Ft. Benning, Georgia, and later to Randolph Field, Texas.

Previously superintendent of the Central State Hospital, Waupun, for three years, Captain Jefferson F. Klepfer is now in the service of the Army Medical Corps. He is on leave of absence from his hospital position for the duration of the war. His first assignment was Carlisle Barracks, Pennsylvania, where he reported early in August to attend a six weeks course in military medicine.

Before assuming the superintendency of the Central State Hospital, Captain Klepfer was a psychiatrist on the staff of St. Mary's Hill sanatorium, Milwaukee, from 1936 to 1938. From July 1, 1931 to September 1, 1936, he served in the capacities of junior and senior physician and clinical superintendent of the Richmond State Hospital, Richmond, Indiana. Immediately following his graduation from the Indiana University School of Medicine, he was a physician on the staff of the Marine Hospital, Chicago, under the United States Public Health Service.

Formerly director of the Columbia Hospital serum center, associate director and diagnostician of South View Hospital, and instructor in medicine and therapeutics at the Marquette University School of Medicine, all in Milwaukee, **Lieutenant Colonel Maurice Hardgrove** is now in charge of the internal medicine department of the Gorgas Hospital in the Panama Canal Zone following his recent promotion in rank.

Lieutenant J. H. Biller, Milwaukee, is finding life in the army interesting and even amusing at times.

"(The following letter was written to Capt. Arthur W. Hankwitz by 1st Lt. James H. Biller, M. C., Camp Kohler, California.)

"Well, here I am! I have not stopped traveling. My final station (I hope) is at the Station Hospital, Camp Kohler, California. This is 12 miles from Sacramento.

"I am in charge of a Dispensary; do the skin consultations and have a skin ward. I am very much interested in Dermatology and I doubt very much whether I will go back to general practice. I probably will take additional postgraduate work at some University (providing I don't get my head knocked off before that time.)

"You know the routine of Army life: the only good thing about it is that I am through at 4:30 P. M., no night calls—that is a lie! Let me tell you a story:

"Last week I was on duty on top of the Sierra Nevada mountains. I was on a bivouac with some troops (Signal Corps). My tent is equipped with telephone communication with nearby towns. About 3:00 A. M. a call came through from a town 36 miles away—'would the medical officer take a confinement case—emergency since they were unable to locate their doctor.' How do you like that?

"Even an Army officer—7,000 feet up on the Sierra Nevada Mountains can be attacked by a confinement.

"The only nice thing about it was that I did not make the call since I was not allowed to leave my post. So no doubt the baby was born in spite of the doctor.

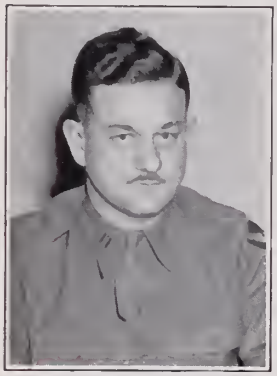
"While up in the mountains, I had a chance to do a little trout fishing—this is great sport in those

mountain streams and lakes. We got those small speckled and rainbow trout. It is a real camping or outing at Government expense. The only trouble is that it is somewhat cold—5 blankets and 2 comforters come in handy. But still I almost froze my left arm off.

"Each officer is required to spend 6 days on duty up in the mountains.

"Mrs. Biller and my son arrived here a few days ago, and I now have my car which gives me a little added convenience. The camp is about 12 miles from Sacramento, so that I drive out and back each day. My wife will probably stay out here until fall and then will return to see how things are getting along in Milwaukee."—From "Medical Corps" in the August, 1943, issue of *The Reservist.*

Information received from his Milwaukee office reveals that **Lieutenant W. Whitcomb Busby** is now stationed at the Naval Base Hospital, San Diego, California. Lieutenant Busby left Milwaukee the middle of August.



T. A. HELLER

Captain T. A. Heller, formerly a practicing surgeon in Milwaukee, is in the service of the Air Transport Command, in which he recently was promoted from the rank of lieutenant.

Writing from the Station Hospital, Jefferson Barracks, Missouri, **Lieutenant Edward T. Hougen** states that he entered the service of the United States armed forces on June 3, 1943, and attended the Medical Field Service School at Carlisle Barracks until July 15. Of this training he says, "I enjoyed the course of instruction there and learned much about the organization of the Army and the Medical Department, its functions and manner of operation." From Carlisle Barracks he was transferred to his present station, where he has been in the Out Patient Clinic working with ambulatory patients of all types.

At the time of writing, Lieutenant Hougen was awaiting further orders and assignment to another station.

On duty at Camp Adair, Oregon, **Major John F. Cary** is the recent appointee to a new military rank. A graduate of the University of Notre Dame and the Loyola University School of Medicine, he was a practicing physician at Sheboygan when he was called to active duty.

After having practiced medicine in Prairie du Chien for the last twelve years, **Lieutenant Herman L. Shapiro** is now at Carlisle Barracks, Pennsylvania, where he is taking his indoctrination training in the United States Army. His subsequent assignment will be a camp in Arkansas. Lieutenant Shapiro closed his office on Saturday, August 25.

Mrs. Shapiro and children are remaining in Prairie du Chien for the duration.

In supplying the Secretary's office with a new address, **Captain C. S. Milchen**, a former Blair physician who is somewhere in Australia, describes differences apparent in Australian customs. He writes, "It is winter here, and it resembles our fall. It seems that I'm carrying my ole shotgun and there should be a big rooster in that stretch of weeds; sure makes a feller think of home. I rather like Australia thus far. Interesting enough is the way the Aussies eat. They drive on the left hand side of the road and even walk on the left hand side of the sidewalk. The handles on their bikes point forward, and to us the monetary system is somewhat mixed up."

Captain Milchen reports that he looked up **Captain C. J. Moran**, La Crosse, and that he looks fine. He did not see **Lieutenant Colonel S. W. Hollenbeck**, Milwaukee, a medical battalion surgeon in that region, as he was away at school.

Several of the men in service at Captain Milchen's base experienced the Buna campaign and saw quite a bit of action. Having talked to quite a few of them, Captain Milchen states, "Their spirits are high and ready for any eventuality. They are a great bunch."

Telling about his work overseas, **Captain Walter F. Lappley**, Madison, writes as follows: "I am still in the North African theater but am doing quite a bit of medicine and surgery. We began to function about three weeks after we arrived here and have been kept quite busy since. It is our opinion that an Evacuation Hospital is the choice spot in the medical service. It is closest to the front of any field unit that is able to handle all types of cases. We get them after they have had only first aid. We operate on them, keep them about ten days and then evacuate them to the rear to station and general hospitals for convalescence. If we get too rushed and the patients are in good enough condition we can evacuate them immediately after surgery.

"I found Army service in the states rather uninteresting but have enjoyed every moment of my overseas service."

Wisconsin Physicians in Service—Recent Appointments*

Ashland County

Kreher, J. E., Ashland

Brown County

Cochrane, W. L., Wayside
Merline, G. B., Green Bay

Clark County

Frank, H. A., Neillsville

Columbia County

Dibble, H. C., Portage
Irwin, W. G., Lodi
Saxe, Jack, Jr., Portage

Crawford County

Shapiro, H. L., Prairie du Chien
Farrell, J. J., Prairie du Chien

Dane County

Dean, F. K., Madison
Gallagher, J. T. F., Madison
Joyner, T. H., Oregon
Kjervik, A. R., Madison
Krehl, W. H., Madison
Lohmiller, B. D., Madison
Swafford, K. P., Madison
Tweeten, J. K., De Forest
Zantow, F. E., Madison

Dodge County

Klepfer, J. F., Waupun

Fond du Lac County

Clark, C. J., Fond du Lac

Green County

Kindschi, L. G., Monroe

Iowa County

Dieter, D. G., Cobb

Jefferson County

Zimmerman, F. H., Watertown

La Crosse County

Anderson, P. D., La Crosse
Bayley, W. E. G., La Crosse

Milwaukee County

Baker, V. L., Wauwatosa
Baumann, A. J., Milwaukee
Berner, C. L., Milwaukee
Brewer, B. J., Milwaukee
Champney, R. D., Milwaukee
Coffey, W. L., Jr., Milwaukee
Currer, P. R., Milwaukee
French, G. A., Milwaukee
Heil, J. V., Milwaukee
Henry, R. B., Milwaukee
Keating, D. R., Milwaukee
Kores, A. B., Milwaukee
Kores, V., Milwaukee
Low, N. L., Milwaukee
McDonald, R. E., Milwaukee
Meyer, K. H., Milwaukee
Morter, H. V. N., Milwaukee
O'Donovan, E. J., Milwaukee
Pachefsky, S. L., Milwaukee
Park, C. F., Milwaukee
Rikkers, D. F., Milwaukee
Robbins, L. S., Milwaukee
Robinson, T. N., Milwaukee
Rosenbaum, M. K., Whitefish Bay
Rotter, E. J., Milwaukee
Schroeder, J. D., Milwaukee
Swanson, R. F., Milwaukee
Tegtmeyer, G. F., Milwaukee
Twelmeyer, H. F., Milwaukee
Weigler, R. R., Milwaukee
Ziegler, C. T., Milwaukee

Oneida County

Schiek, I. D., Rhinelander

Outagamie County

Adrians, W. A., Hortonville

Rock County

Baumgartner, M. M., Janesville
Freitag, S. A., Janesville
Ross, M. E., Beloit

Sheboygan County

Limberg, P. W., Plymouth

Trempealeau County

Haines, Brunetto, Arcadia

Walworth County

Niles, E. W., Whitewater

Waukesha County

Davies, G., Waukesha
Olsen, L. C. J., Delafield
Wilkinson, D. C., Oconomowoc

Winnebago County

Kuhn, R. V., Oshkosh
Mathwig, R. J., Oshkosh

Wood County

Miller, G. E., Marshfield
Triggs, P. O., Wisconsin Rapids
Wood, C. A., Marshfield

* July 20 to August 31, 1943.

GAS WARFARE SCHOOLS

Gas Warfare Schools for physicians scheduled for early November will be held in Madison, Eau Claire, and Superior. The postgraduate gas warfare schools have been approved by the Council on Scientific Work of the Society and the Emergency Medical Service Division of the Wisconsin Council of Defense.

Schools will be held in Madison, Fond du Lac, Oshkosh and Beloit the latter part of October.

The November schedule is as follows:

Tuesday,	November 2,	7:30 p.m. to 10:30 p.m.	Eau Claire
Wednesday,	November 3,	10:00 a.m. to 11:00 a.m.	Eau Claire
Wednesday,	November 3,	7:30 p.m. to 10:30 p.m.	Eau Claire
Thursday,	November 4,	7:30 p.m. to 10:30 p.m.	Superior
Friday,	November 5,	10:00 a.m. to 11:00 a.m.	Superior
Friday,	November 5,	7:30 p.m. to 10:30 p.m.	Superior

THE WISCONSIN MEDICAL JOURNAL

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« « « EDITORIAL » » »

Much comment has been heard concerning the Emergency Maternal and Infant Care program of the Children's Bureau in Washington, supported by large federal appropriations, and available to the wives and children of certain noncommissioned classifications of men in service.

A special report of the Society's Committee on Maternal and Child Welfare was considered by the House of Delegates at the annual meeting. As a result, it has become the position of the House to affirm the action taken by the House of Delegates of the American Medical Association approving the action of the federal government in making funds available for this purpose, but urging adoption of a plan under which stated allotments may be made available similar to dependents' allotments, leaving the actual arrangement with respect to fees to be fixed by mutual agreement with the wife and the physician of her choice.

Urging that this program be accepted for the duration only, the delegate body of this Society stressed that in the extension of care to these individuals the same high qualifications of the medical corps of the several branches of the armed forces should be maintained. In the October issue of the *American Journal of Obstetrics and Gynecology* appears the following editorial emphasizing that adequate obstetric standards must be maintained in the program. Effectively phrased, it is quoted here extensively.

The E. M. I. C. Program

"IT MAY be stated as a proved fact that the efforts to provide safe care in maternity have been crowned with success if we measure this by the marked reduction in mortality rates which has been prevalent in recent years throughout most of these United States. Improvement in standards concerned with doctors, nurses, hospitals, and public health services, whenever and wherever applied, has saved undoubtedly the lives of many mothers and babies. It is a record of which this country may well be proud.

"The participation by the United States in the global war has called for the institution of health measures affecting our entire population, prominent among which is the care of prospective mothers who are the wives of men enlisted in the lower ranks of the Armed Forces and whose pay, it is assumed, would be insufficient to provide adequate and proper maternity service for their dependents. The Federal Government has undertaken to furnish what essentially is a supplement to the soldier's pay and a carefully studied act has been developed through the agency of the Children's Bureau by which a large sum of money was appropriated by Congress for this purpose. The provisions of the act have been accepted by most of the States in the Union although many of its administrative and other features leave much to be desired. However the medical profession has given its support and is wholeheartedly prepared to fulfill its functions. It recognizes, as do other interested agencies, that only the highest standards should prevail but it protests the perversion of the purposes of the Maternal Welfare Act by the amendment to the same appended by Congress at a last minute. As it stands the Bill approved by the President contains the following proviso relating to appropriations for the Department of Labor:

> " 'Provided, that no part of any appropriation contained in this title shall be used to promulgate or carry out any instruction, order, or regulation relating to the care of obstetrical cases which discriminates between persons licensed under state law to practice obstetrics: Provided further, that the foregoing proviso shall not be so construed as to prevent any patient from having the services of any practitioner of her own choice, paid for out of this fund, so long as state laws are complied with.'

"The high standards set up by the Children's Bureau in cooperation with its Board of Consultants are undermined by this amendment which, to their great credit, was vigorously opposed by several outstanding members of the Senate. A principal one among the arguments advanced in Congress during the debate on the measure was to the effect that the original, unamended bill constituted an 'invasion of states rights,' whatever that may mean in the face of other 'invasions' in recent years. Such argument constitutes a mere political subterfuge, perhaps to satisfy the growing legion of cultists of all types who already have prevailed upon state legislatures to grant them certain, although often restricted, rights of practice.

"A measure of this kind calls attention to one of the weaknesses inherent in political dictation of medical practice and should not be tolerated. Untrained and inadequately trained individuals undertaking the care of pregnant women and operating with the encouragement of the Government will constitute a menace to our prospective mothers and their children. It is quite needless to point out the resulting deaths and injuries which are sure to follow. Every physician with the welfare of his community at heart owes it to himself and his profession to convey to his congressional representative a vigorous protest as soon as possible.

"The casualties of war, whether by death or invalidism, among our young married men in the ranks, emphasize the importance of giving proper care to their wives during childbirth. The mere provision of offering such care means little unless high standards are maintained.

. . . . THE PRESIDENT'S PAGE . . . .

ANOTHER annual meeting of your Society has passed into history. In retrospect it added little to that already written. That fact is not to be wondered at, because there is so little background for constructive rationalizing on problems pertaining to medical economics and because there is so little policy in evidence. The set agenda necessary to accomplish the routine work rolls on; much that is pertinent in the reports of officers and committees is considered in committee, and their conclusions are well conceived, accepted with little being known of their content by the assembled delegates.

The organization of medicine is, as I emphasized in my address, a democratic one and opens the way for anyone informed to make his ideas or reactions heard, but none are forthcoming, much to the detriment of medicine in this state and on the national level.

You are asking for a breakdown in representation on every level of your organization when you fail to make known your thoughts on our problems. The few of you who heard Father Schwitalla (and I hope all of you will read his paper soon to be published in *The Journal)* must realize that great problems of basic importance confront us. We shall fail unless we all get a fundamental knowledge of the facts and fancies creeping into our economic set-up, know what to do, and do it.

I hold our dogmas to be sound. They are essential to good medical service; but I also hold our interpretation of them to be faulty in execution. A return to their precepts is necessary to protect us against developments that will forever abrogate our rights to hold them as the tenets of our structure. What we refuse to do for ourselves will never be done by the public or legislative bodies. We may abrogate our principles directly or by tacit hypothecation; either will create patterns inimicable to our maintaining the bulwarks of medicine against predatory ideologies and uninformed reactionaries. You will preserve only what your willingness to fight for with intelligence and honesty of purpose can keep from being dissipated into realms of influence not medical.

Leadership will avail you nothing at all if you will not hear its clarion call. Expedients only beg the issue; our use of them will eventually shame us. Some things appear hysterical to those who cannot recognize the face of jeopardy.

Medical and Public Opinion Mounting Against Health Bill

DURING the past two months there has been a mustering of medical and public opinion against the Wagner–Murray–Dingell bill which indicates an awareness by the medical profession and the public of the tremendous stake that they have in this legislation, *The Journal of the American Medical Association* for September 4 points out. *The Journal* calls for unity in the medical profession in the attack on the technic for rendering medical service proposed by this legislation. *The Journal* says:

"Hearings on the Wagner–Murry–Dingell bill, which was fully analyzed by the Bureau of Legal Medicine and Legislation of the American Medical Association and commented on editorially in *The Journal,* June 26, will no doubt be held in the near future, probably after Congress has completed the new tax bill. According to the *United States News,* advocates of the expansion program for social security assert that it has caught the popular fancy, that pressure for its adoption is increasing daily, that the plan is a big step toward one of the Four Freedoms of the Atlantic Charter—Freedom from Want—and that Congress would face a storm of public criticism if it failed to approve the main provisions of the plan. On the other hand, opponents assert that the program would constitute a capital levy of ruinous magnitude on United States business, that even with the 12 per cent payroll tax the plan would be underfinanced, and that, should Congress enact such a bill, a dominant bureaucracy would be created which would end free enterprise in the United States and alter the whole way of American life.

"The editorial published in *The Journal* on June 26 emphasized that this bill is an evolution of the National Health Conference of 1937. It pointed out further that the measure was prepared without consultation with the medical profession, that it would make the Surgeon General of the United States Public Health Service a virtual 'gauleiter' of American medicine and that it would be, in fact, the acme of bureaucratic control of medical service. In the two months that have passed there has been a mustering of medical and public opinion against this measure, indicating awareness by the medical profession and the public of the tremendous stake that they have in this legislation. The editor of the McKeesport (Pa.) *Daily News* states the case succinctly:

> It would place the doctors under political control and provide for the mass of the people physicians who are politically amenable rather than those with superior abilities and skills. And would deaden one of the most highly regarded professions the world has ever known. . . . Success of bill 1161 and the destruction of the freedom of American medicine would be the come-on for other broader, more revolutionary schemes to circumscribe the American people.

"The periodical *America* says, in a statement by one of its editors:

> Now, will public regimentation of health servants operate to preserve the profession and thus ultimately help to preserve the body politic? It seems that such action—as, for example, that contemplated in Senate bill 1161—would create a new class of political doctors. And in America political classes are commonly subject to the influence of political practice, in seeking emoluments and avoiding burdens, unless we take the rare case of the unusually elevated individual. The system as it works does not raise personal ideals. But doctors without high personal ideals are a menace, both to the patient and to the public.

"An editorial in the Middletown (Ohio) *News Signal* says:

> The Wagner bill will be considerably modified, but some of its worst features may become law unless it is seen in its true light. It is part of a program, now well advanced, to enslave the individual to the state. In this process he gradually loses his adult self reliance, lapses toward infancy and then degenerates into a willing slave of government.

"The Charleston (S. C.) *News–Courier,* in a sarcastic editorial contribution, emphasizes the political aspects of this measure. It suggests that the medical administrators under the Wagner–Murray–Dingell bill be elected

by popular ballot. The medical administrator would have the right to appoint the doctors and assign the cases. He could expect the support of the doctors that he appointed to help him get reelected, and the doctors would use their automobiles and C cards to help haul voters to the polls. They could also contribute to a fund to buy radio time for campaign speakers. Any doctor who worked against the medical director's reelection might find it difficult afterward to practice. Appointments in the medical colleges would, of course, be handled like other political patronages so that deserving party members could have their sons trained free of charge. Incidentally, it is pointed out, a lot of useful confidential information could be picked up by the doctors on their rounds that would help the party to stay in office.

"And the Jackson (Tenn.) *Sun* comments metaphorically:

> We are indeed a sick nation if we are willing to swallow such a pill. After swallowing it we would find that, instead of taking a progressive stimulant, we had taken a political opiate intended to dull our senses. . . .

"The editor of the Buffalo *News* suggests that the proposed measure provides for a setup 'closely approaching that in the totalitarian nations.' He urges, furthermore, that the people, if they have put upon them the full measure of social security proposed by the New York senator, 'soon would be in a condition to yield themselves up as wards of the state.'

"At its meeting held in Chicago on August 26, the American Bar Association gave its approval to a resolution opposing any legislation now before Congress which 'seeks to establish federal control of the medical profession and the regimentation of doctors and hospitals.'

"The periodical *Medical Care,* edited by Mr. Michael Davis, suggests that the Wagner–Murray–Dingell bill was introduced on the demand of organized labor for the expansion of social security and that the timing may be accounted for by the probability that realists who are pushing this bill are more hopeful of dramatizing an issue for 1944 than of congressional action this year. The editorial indicates, incidentally, that the bill goes beyond the plans put forth by the President and the Social Security Board.

"In his editorial Mr. Michael Davis suggests that American physicians can now be divided into three groups: those who support the policies of the American Medical Association, those who differ with them but who keep silent and those who differ and say so publicly. Mr. Davis takes great encouragement from the statement recently released by Drs. John Peters, Channing Frothingham and others which apparently indicates to him a division in the medical profession and a gathering of strength against the policies of the American Medical Association.

"Already an announcement has been made in the press that Senators Wagner and Murray propose to have early hearings on this measure. Certainly the Board of Trustees and the newly established Council on Medical Service and Public Relations will give early consideration to the manner in which the American Medical Association is to be efficiently represented in the proposed hearings.

"Regardless of any other considerations on which there might be a difference of opinion among the vast majority of physicians of the United States, unity is demanded in the attack on the technic for rendering medical service proposed by the Wagner–Murray–Dingell bill. Senator Wagner in his public statement said 'I do not claim this bill is in any sense a perfect instrument; it is offered simply as a basis for legislative study and consideration.' Let us take the Senator at his word and prove to him and his colleagues, by a complete and forceful presentation of the points of view of American medicine, how far from perfect is the measure that he has proposed."

Someone said that of all the millions of species of living organisms on the earth the two about which most had been written were man himself and—the tubercle bacillus. *Biological Aspects of Infectious Disease.* F. M. Burnet, M.D. 1940.

One Hundred Second Anniversary Meeting Declared a Huge Success

Dr. Charles H. Fidler, Milwaukee, Named President-Elect

THE One Hundred Second Anniversary Meeting was declared an unqualified success by all members attending the sessions in Milwaukee. With a registration identical to that of the Centennial Meeting held in 1941, the officers of the Society and members of the Council on Scientific Work were highly gratified with the attendance at the sessions in the Milwaukee Auditorium.

New Officers Chosen

The House of Delegates unanimously elected to office the following members recommended by the Committee on Nominations for the various offices of the Society:

Charles H. Fidler, Milwaukee—President-elect
P. R. Minahan, Green Bay—Speaker of the House of Delegates
C. A. Dawson, River Falls—Vice-speaker
W. D. Stovall, Madison—Delegate to the American Medical Association
H. A. Sincock, Superior—Alternate Delegate

Other officers elected or re-elected are the following councilors:

C. O. Vingom, Madison—Third District
E. H. Spiegelberg, Boscobel—Fourth District
S. E. Gavin, Fond du Lac—Sixth District
A. H. Heidner, West Bend—Eighth District
R. W. Blumenthal, Milwaukee—Twelfth District

President Kurten Makes Appointments

At the Tuesday morning session of the House of Delegates, the House confirmed the following committee appointments recommended by President Kurten:

To the Committee on Cancer

Dr. L. J. Van Hecke, Milwaukee, chairman
Dr. A. R. Curreri, Madison, appointed
Dr. L. W. Peterson, Shawano, appointed

To the Advisory Committee on Care of Crippled Children

Dr. T. L. Squier, Milwaukee, appointed
Dr. W. P. Blount, Milwaukee, appointed
Dr. J. B. MacLaren, Appleton, to continue as chairman

To the Committee on Coordination of Medical Services

Dr. J. W. Prentice, Ashland, appointed
Dr. C. O. Vingom, Madison, to continue as chairman

To the Committee on Goiter

Dr. E. W. Schacht, Racine, appointed
Dr. A. S. Jackson, Madison, to continue as chairman

To the Committee on Grievances

Dr. W. W. Kelly, Green Bay, new appointee and chairman

To the Committee on Health and Public Instruction

Dr. Norbert Enzer, Milwaukee, new appointee and chairman

To the Committee on Hospital Relations

Dr. M. L. Jones, Wausau, reappointed
Dr. E. O. Gertenbach, Milwaukee, reappointed
Dr. J. E. Habbe, Milwaukee, to continue as chairman

To the Committee on Industrial Health

Dr. M. J. Reuter, Milwaukee, appointed
Dr. Gunnar Gundersen, La Crosse, to continue as chairman

To the Committee on Maternal and Child Welfare

Dr. W. C. Stewart, Kenosha, appointed
Dr. W. A. Wagner, Oshkosh, appointed
Dr. A. C. Radloff, Plymouth, to continue as chairman

To the Committee on Medical Economics and Voluntary Sickness Insurance

Dr. Robert Krohn, Black River Falls, reappointed
Dr. J. E. Habbe, Milwaukee, appointed
Dr. D. H. Witte, Milwaukee, to continue as chairman

To the Committee on Medical Education and Hospitals

Dr. C. R. Marquardt, Milwaukee, appointed
Dr. F. D. Murphy, Milwaukee, to continue as chairman

To the Committee on Mental Hygiene and Institutional Care

Dr. A. W. Bryan, Madison, appointed

To the Committee on Public Policy

Dr. E. C. Cary, Reedsville, appointed
Dr. C. A. Dawson, Rivers Falls, to continue as chairman

To the Committee on Tuberculosis and Chest Diseases

Dr. L. O. Simenstad, Osceola, reappointed and to continue as chairman

To the Council on Scientific Work

Dr. C. F. Midelfort, Eau Claire, appointed
Dr. F. D. Murphy, Milwaukee, chairman

To the Advisory Committee on Visual and Hearing Defects

Dr. T. J. Doyle, Superior, appointed.

Special Council Committees

The following special committees of the Council have been named by Dr. Gavin:

Committee Advisory to the Veterans Recognition Board

Dr. B. J. Hughes, superintendent of Winnebago State Hospital, chairman (Psychiatrist)
Dr. R. P. Montgomery, Milwaukee (Orthopedist)
Dr. A. J. Wiesender, Berlin (General practitioner)

Committee on War Records

Dr. R. W. Blumenthal, Milwaukee, chairman
Dr. A. H. Gundersen, La Crosse
Dr. K. K. Borsack, Fond du Lac

Obstetric Manikin Demonstrations a Popular Feature

One of the most popular features of the meeting was the obstetric manikin demonstrations held on the stage of the main arena of the Auditorium. Each morning and afternoon, nearly 250 physicians witnessed and heard this feature presented by three guest physician-demonstrators: W. F. Mengert, Iowa City; M. E. Davis, Chicago; and C. P. Huber, Indianapolis.

Each of the other scientific exhibits drew a large attendance throughout the three days of the meeting. The exhibits attracting special attention were the applied anatomy exhibits of the Marquette University School of Medicine and the University of Wisconsin Medical School, the exhibit on tropical medicine by Dr. Marcos Fernan-Nunez, Milwaukee, and the exhibit of the Vocational Training of the Blind by the School for the Blind, Janesville. The rapt attention given all the exhibits was irrefutable evidence of their popularity and their value as a teaching medium.

Each year has witnessed increasingly greater emphasis being placed on the scientific exhibits by the Council on Scientific Work with a corresponding evidence of increased interest being demonstrated by members attending the sessions.

PAST-PRESIDENTS' LUNCHEON
Left to Right: R. P. Sproule, C. A. Harper, L. E. Dockery, E. J. DeCosta, W. E. Ground, F. G. Connell, Gunnar Gundersen, R. M. Kurten, A. E. Rector, J. F. Smith, S. E. Gavin, J. E. Paullin, R. G. Arveson, A. J. Patek.

Section on Hospital Relations

"The response from physicians and hospital personnel far exceeded the committee's expectations," declared J. E. Habbe, chairman of the Society's Committee on Hospital Relations in commenting on the attendance at the morning sessions of the Section on Hospital Relations. "Enthusiastic as I was," continued Dr. Habbe, "I never dreamed there would be so many interested that the number of luncheon guests would tax the capacity of this large room."

Father Alphonse Schwitalla discussed with the physicians and the hospital representatives at the noon luncheon "Administrative and Professional Problems of Medical Practice in the Hospital." Tentative plans call for the publication of his presentation in an early issue of *The Journal.*

A new venture this year, the Section on Hospital Relations owes much of its success to the time and effort directed to its development by its chairman.

Smoker Rated as "Best Ever"

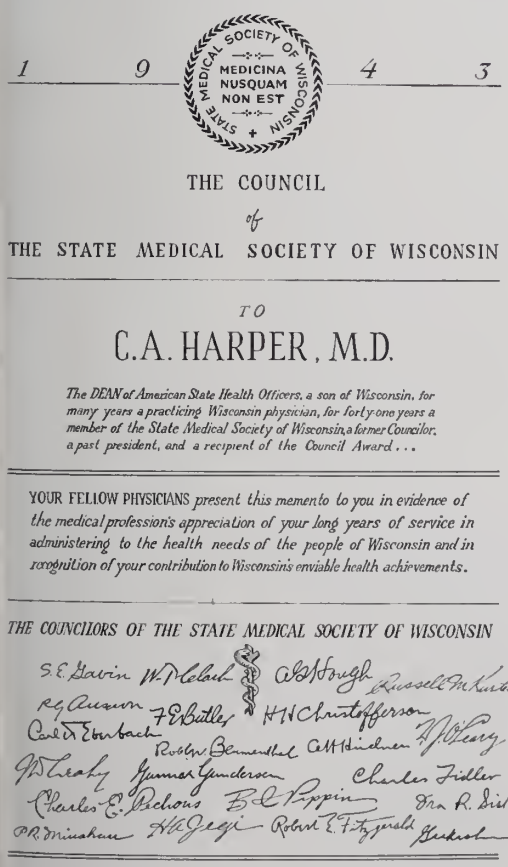
When members attending the smoker called attention to the ability of L. J. Van Hecke as a master of ceremonies and an imitator of merit and excellence, he was pressed

into service by the demands of the audience. So enthusiastically were his presentations received that he was recalled time and again to the stage.

Lovers of old time songs welcomed the vocal selections sung by the Blatz Quartet, entertainment made available by the Blatz Brewing Company.

C. A. Harper Honored

At the time that C. A. Harper resigned as State Health Officer, the Council of the Society directed that a suitable memento to Dr. Harper be prepared commending him on the enviable record made during his stewardship of the State Board of Health. The occasion chosen for the presentation of the Scroll of Appreciation was the Annual Dinner on Tuesday evening. In making the presentation, Dr. Gavin, chairman of the Council, said: "Dr. Harper, in 1930 you were honored by the State Medical Society through the presentation of the Council Award, the highest honor within the power of the Society to bestow upon you. In the intervening thirteen years, you have continued that conscientious and untiring work which merited the Council Award. Now, upon the occasion of your resigning as State Health Officer and as Secretary of the State Board of Health, there is no further honor which this Society can bestow upon you, but it is a privilege to the Council to present you this scroll of appreciation for these many years of service which you have rendered in the interests of the public health of the State of Wisconsin. As chairman of the Council, I am happy to have that privilege."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STATE MEDICAL SOCIETY OF WISCONSIN
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THE COUNCIL
of
THE STATE MEDICAL SOCIETY OF WISCONSIN

TO

C.A. HARPER, M.D.

The DEAN of American State Health Officers, a son of Wisconsin, for many years a practicing Wisconsin physician, for forty-one years a member of the State Medical Society of Wisconsin, a former Councilor, a past president, and a recipient of the Council Award . . .

YOUR FELLOW PHYSICIANS *present this memento to you in evidence of the medical profession's appreciation of your long years of service in administering to the health needs of the people of Wisconsin and in recognition of your contribution to Wisconsin's enviable health achievements.*

THE COUNCILORS OF THE STATE MEDICAL SOCIETY OF WISCONSIN

Annual Dinner

Because it was anticipated that there would be many persons who would make last minute requests for tickets, additional dinner places were ordered. However, the demands far exceeded the number anticipated, with the result that many members were unable to gain admittance to the dinner.

Lieutenant Colonel Walter B. Martin, Battle Creek, Michigan, discussed "The American Doctor at War." In addressing the physicians and their wives, Colonel Martin stressed the imperativeness of training physicians in military procedures and maneuvers so that they would be able to coordinate their activities with the other units of the armed forces. Colonel Martin declared that members of the armed forces in this war are receiving superb medical care. "The mortality of the acute infectious diseases has been held at a minimum, and the mortality from wounds has been far below the record in the first World War" was the reassuring message left with his audience. In relating the reasons for this record, Colonel Martin set forth the following: immediate administration of blood plasma, administration of morphine, prompt transportation to base hospitals, well trained medical officers, and use of the sulfa drugs.

James E. Paullin, Atlanta, Georgia, president of the American Medical Association, outlined some of the problems which will face the profession in the postwar period and urged the individual physician and the

Society to focus their attention on these problems and to direct their best thought at once to the solution of them. The organized medical profession, which will celebrate its one hundredth anniversary in 1947 on a national level, has ever been in the forefront to encourage and nurture those measures which assured sound public health progress. Health programs, panaceas, schemes, and devices which are propounded must be examined thoroughly to the end that those which are found to hold promise of public benefit may be established. The attention of the profession should be directed especially to the operation of medical care plans and to the field of industrial health. Those members of the State Medical Society of Wisconsin and members of the American Medical Association who are serving in the armed forces will hold to account the profession at home for the stewardship of the public health and the practice of medicine.

Registrants

Adams
Ingersoll, B. P., Adams
Schmallenberg, H. C., New London

Ashland
Grigsby, R. O., Ashland
Prentice, J. W., Ashland
Smiles, C. J., Ashland

Barron
Adams, R. W., Chetek
Lund, S. O., Cumberland

Brown
Cowles, R. L., Green Bay
Boles, C. S., Camp Wolters, Tex.
Jordan, E. M., Green Bay
Kelly, W. W., Green Bay
Killins, W. G., Green Bay
Levitas, I. E., Green Bay
McNevins, E. S., Green Bay
Michna, C. T., Denmark
Milson, Louis, Green Bay
Minahan, P. R., Green Bay
Nadeau, E. G., Green Bay
O'Brien, E. J., Green Bay
Quigley, L. D., Green Bay
Robb, J. J., Green Bay
Schmidt, E. S., Green Bay
Shinners, G. M., Green Bay
Stiennon, O. A., Green Bay
Tippet, W. P., Green Bay
Troup, R. L., Green Bay
Waldkirch, R. M., De Pere

Buffalo
Johnson, B. F., Mondovi

Burnett
Sherman, L. F., Chicago (Siren)

Calumet
Engel, A. C., New Holstein
Knauf, N. J., Chilton
Minahan, J. J., Chilton

Chippewa
Daly, F. P., Chippewa Falls
Hatleberg, C. N. Chippewa Falls
Hunter, R. R., Chippewa Falls
Rodgers, R. S., Chippewa Falls
Sazama, J. J., Bloomer
Williams, S. E., Chippewa Falls

Clark
Christofferson, H. H., Colby
Johnson, J. W., Withee
Hable, A. P., Loyal
Overman, M. V., Neillsville

Columbia
Caldwell, H. M., Columbus
Gillette, H. E., Pardeeville
Henney, C. W., Portage
Mudroch, J. A., Columbus
Tierney, E. F., Portage

Crawford
Armstrong, C. A., Prairie du Chien
Dessloch, E. M., Prairie du Chien
Kleinpell, H. H., Prairie du Chien
Rauchschwalbe, L. E., Wauzeka

Dane
Aageson, C. W., Madison
Brehm, P. A., Madison
Bryan, A. W., Madison
Burns, R. E, Madison
Cameron, E. S., Madison
Campbell, R. E., Madison
Carter, H. M., Madison
Cole, L. R., Madison
Coluccy, M. J., Madison
Coon, H. M., Madison
Cooper, G. A., Madison
Curreri, A. R., Madison
Davis, F. A., Madison
Davis, H. P., Madison
Dean, J. C., Madison
Dickie, H. A., Madison
Duehr, P. A., Madison
Ellis, I. G., Madison
Erickson, T. C., Madison
Fauerbach, Louis, Madison
Filek, A. A., Madison
Froggatt, W. E., Cross Plains
Gaenslen, F. G., Madison
Ganser, W. J., Madison
Gonce, J. E., Madison
Grab, J. A., Madison
Grumke, E. H., Madison
Harris, J. W., Madison
Hill, N. A., Madison
Hunter, A. L., Madison
Hurlbut, J. A., Madison
Hyslop, V. B., Madison
Jackson, A. S., Madison
Jackson, J. A., Madison
Jackson, R. H., Madison
Jaeschke, W. H., Madison
Keenan, H. A., Stoughton
Kurtz, C. M., Madison
Leonard, T. A., Madison
Lindsay, W. T., Madison
Lorenz, W. F., Madison
Maloof, G. J., Madison
Marsden, W. H., Madison
Masten, M. G., Madison
McCabe, J. M., Sun Prairie
McCarter, J. C., Evanston, Ill.
McCormick, S. A., Madison
McDonough, K. B., Madison
McGary, Lester, Madison
McIntoch, R. L., Madison
Mohs, F. E., Madison
Mowry, W. A., Madison
Neff, E. E., Madison
Nelson, E. J., Sun Prairie
Nereim, T. J., Madison
Nesbit, M. E., Madison
Nesbit, W. M., Madison
Neupert, C. N., Madison
Paul, L. W., Madison
Pessin, S. B., Madison
Peters, M. P., Madison
Quisling, Sverre, Madison
Reed, H. L., Madison
Reznichek, C. G., Madison
Ritchie, Gorton, Madison
Sauthoff, A., Mendota
Schmidt, E. R., Madison
Schneiders, E. F., Madison
Schoenbeck, R. F., Stoughton
Schubert, C. K., Madison
Schultz, Isadore, Mazomanie
Schwittay, A. M., Madison
Shumate, J. K., Madison
Sevringhaus, E. L., Madison
Sprague, L. V., Madison
Stebbins, G. G., Madison
Stebbins, W. W., Madison
Stovall, W. D., Madison
Supernaw, J. S., Madison
Tenney, H. K., Madison
Tormey, A. R., Madison
Tormey, T. W., Madison
Trautmann, M., Madison
Urben, W. J., Mendota
Van Gemert, J. G., Madison
Vingom, C. O., Madison
Waddell, J. G., Madison
Wheeler, R. M., Madison

Williams, D. L., Madison
Wirka, H. W., Madison
Wynn, S. K., Madison

Dodge
Bachhuber, F. G., Mayville
Costello, W. H., Beaver Dam
Federman, E. H., Horicon
Hough, A. G., Beaver Dam
Hoyer, G. H. C., Beaver Dam
Quackenbush, E. C., Iron Ridge
Raymond, R. G., Brownsville
Ries, M. F., Brownsville

Door
Beck, J. G., Sturgeon Bay
Dorchester, D. E., Sturgeon Bay

Douglas
Ekblad, V. E., Superior
Finn, Milton, Superior
Ground, W. E., Superior
McGill, J. W., Superior
Sincock, H. A., Superior

Dunn
Halgren, J. A., Menomonie
McMahon, A. E., Menomonie

Eau Claire
Cook, F. S., Eau Claire
Derge, H. F., Eau Claire
Haag, A. F., Eau Claire
La Breck, F. A., Eau Claire
Lowe, J. W., Eau Claire
Manz, W. R., Eau Claire
Midelfart, C. F., Eau Claire
Richards, R. R., Eau Claire
Spelbring, P. G., Eau Claire
Stang, H. M., Eau Claire

Fond du Lac
Bachus, A. C., Ripon
Borsack, K. K., Fond du Lac
Folsom, W. H., Fond du Lac
Gavin, S. E., Fond du Lac
Guenther, O. F., Campbellsport
Guth, H. K., Waupun
Hebenstreet, A. J., Waupun
Hoffman, L. A., Campbellsport
O'Neal, Orvil, Ripon
Reslock, C. P., Waupun
Simon, L. J., Fond du Lac
Smith, E. V., Jr., Fond du Lac
Twohig, D. J., Fond du Lac
Walters, D. N., Fond du Lac
Watson, E. L., Ripon
Werner, H. C., Fond du Lac
Yockey, J. C., Fond du Lac

Grant
Andrew, C. H., Platteville
Doeringsfeld, H. L., Platteville
Hayman, C. S., Boscobel
Randall, M. W., Blue River
Schuldt, C. M., Platteville
Soles, F. A., Platteville
Spiegelberg, E. H., Dodgeville
Terry, R. E., Cuba City

Green
Baumle, C. E., Monroe
Fillbach, H. E., Monroe
Francois, S. J., New Glarus
Kundert, F. W., Monroe
Moore, L. A., Monroe

Green Lake
Kelly, J. A., Green Lake
Koch, H. C., Berlin
Stone, Mildred, Berlin
Wiesender, A. J., Berlin

Iowa
Hamilton, W. P., Dodgeville
Marshall, S. B., Hollandale
Morton, H. H., Dodgeville
Walter, H. M., Dodgeville

Jackson
Krohn, Robert, Black River Falls

Jefferson
Abelmann, T. C., Watertown
Allen, S. C., Waterloo
Becker, W. C., Watertown
Bertolaet, E. E., Palmyra
Bowen, H. P., Watertown
Brewer, J. C., Jefferson
Caswell, H. O., Ft. Atkinson
Dennis, J. F., Waterloo
Dierker, O. F., Watertown
Eck, G. E., Lake Mills
Gardin, C. J., Jefferson
Gueldner, L. H., Ft. Atkinson
Kosanke, F. E., Watertown
Peterson, M. G., Lake Mills
Robinson, A. H., Jefferson
Schoenecker, E. A., Lake Mills
Venning, J. R., Ft. Atkinson
Waite, W. S., Watertown
Wendt, F. A., Johnson Creek

Juneau
Hess, J. S., Mauston

Kenosha
Binnie, Helen, Kenosha
Bowing, Irwin, Kenosha
Cleary, J. H., Kenosha
Davin, C. C., Kenosha
De Fazio, S. F., Kenosha
Graves, J. P., Kenosha
Lokvam, L. H., Kenosha
Mayfield, A. L., Kenosha
Pechous, C. E., Kenosha
Pifer, P. E., Kenosha
Pirsch, M. V., Kenosha
Rauch, A. M., Kenosha
Richards, C. G., Kenosha
Ruffalo, A., Kenosha
Sokow, Theodore, Kenosha
Stewart, W. C., Kenosha
Ulrich, C. F., Kenosha

Kewaunee
Dana, D. B., Kewaunee
Kerscher, E. J., Casco
Witcpalek, E. W., Kewaunee
Witcpalek, W. W., Algoma
Wochos, F. J., Kewaunee
Wochos, W. M., Kewaunee

La Crosse
Bannen, W. E., La Crosse
Douglas, F. A., La Crosse
Eagan, R. L., La Crosse
Fox, J. C., La Crosse
Gatterdam, P. C., La Crosse
Gundersen, A. H., La Crosse
Gundersen, Gunnar, La Crosse
Gundersen, S. B., La Crosse
Harmon, J. C., La Crosse
Heraty, J. E., La Crosse
McGarty, M. A., La Crosse
Ruppenthal, K. P., Bangor
Seedorf, E. E., La Crosse

Lafayette
Ennis, S. A., Shullsburg
Morrison, M. T., South Wayne

Langlade
Zellmer, C. E., Antigo

Lincoln
Baker, R. G., Tomahawk
Morris, K., Merrill
Ravn, E. O., Merrill

Manitowoc
Andrews, M. P., Manitowoc
Bonner, N. A., Manitowoc
Cary, E. C., Reedsville
Huth, Edgar, Valders
Knauf, F. P., Kiel
Moriarty, L. J., Two Rivers
Nauth, D. F., Kiel
O'Donnell, S. P., Kiel
Rauch, W. A., Manitowoc
Rees, T. H., Manitowoc
Strong, R. G., Manitowoc
Teitgen, T. A., Manitowoc
Yost, R. G., Manitowoc
Zlatnik, A. P., Two Rivers

Marathon
Bachhuber, H. M., Athens
Christensen, H. H., Wausau
Freeman, J. M., Wausau
Frick, Lewis, Athens
Macauley, E. M., Wausau
Schulz, H. A., Edgar
Smith, J. F., Wausau
Smith, S. M., Wausau
Stevens, G. H., Wausau
Trumbo, J. K., Wausau

Marinette
Nadeau, A. T., Marinette
Schroeder, H. F., Marinette
Shaw, R., Marinette

Marquette
Inman, R. F., Montello
McNamara, L. V., Montello

Milwaukee
Ackerman, J. S., Milwaukee
Adamklewicz, J. J., Milwaukee
Allebach, H. K., Milwaukee
Altenhofen, A. R., Wauwatosa
Ansfield, D. J., Milwaukee
Ansfield, M. J., Milwaukee
Augur, A., Milwaukee
Aylward, T. J., Milwaukee
Bachman, C. H., Milwaukee
Baer, A. J., Milwaukee

Bach, M. J., Milwaukee
Baird, K. H., Milwaukee
Baker, V. L., Milwaukee
Banyai, A. L., Wauwatosa
Bardenwerper, H. E., Milwaukee
Barnes, J. S., Milwaukee
Barroek, J. J., Milwaukee
Barta, E. F., Wauwatosa
Baum, E. L., Milwaukee
Beek, R. W., Milwaukee
Beckman, Harry, Milwaukee
Behnke, E. J., Milwaukee
Belknap, E. L., Milwaukee
Bellehumeur, C. E., Milwaukee
Benton, R. W., Milwaukee
Bereey, J. E., Milwaukee
Bernhart, E. L., Milwaukee
Beufler, A. D., Milwaukee
Bickler, F. P., Milwaukee
Biller, S. E., Milwaukee
Blanchard, H. H., Milwaukee
Blankstein, S. S., Milwaukee
Blount, W. P., Milwaukee
Blumenthal, R. W., Milwaukee
Bodden, A. M., Milwaukee
Bolger, J. V., Milwaukee
Borman, M. C., Milwaukee
Bornstein, Max, Milwaukee
Bourne, N. W., Milwaukee
Braumbaugh, E. V., West Allis
Brey, P. F., Milwaukee
Brillman, C. R., Milwaukee
Broadbent, Mary, Milwaukee
Brook, J. J., Milwaukee
Brown, G. V., Milwaukee
Brussoek, W. A., Wauwatosa
Burnett, C. H., Milwaukee
Burbaeh, T. H., Milwaukee
Burgardt, G. F., Milwaukee
Byrnes, M. B., Milwaukee
Cadden, A. V., Wauwatosa
Cahana, Stephen, Milwaukee
Callan, P. L., Milwaukee
Cannon, H. J., Milwaukee
Carey, E. J., Milwaukee
Carhart, G. A., Milwaukee
Carson, W. J., Milwaukee
Ceci, G. E., Milwaukee
Chojnacki, S. L., Milwaukee
Cleveland, David, Milwaukee
Coffey, S. E., Milwaukee
Collentine, G. E., Milwaukee
Conway, J. P., North Carolina
Conroy, C. F., Milwaukee
Cook, E. F., Milwaukee
Cook, H. E., Milwaukee
Coueh, T. T., West Allis
Cox, J. A., Milwaukee
Cox, L. T., Wauwatosa
Crigler, R. R., South Milwaukee
Cron, R. S., Milwaukee
Cunningham, H. A., Milwaukee
Currer, P. M., Milwaukee
Curtin, J. G., Milwaukee
Dallwig, D. L., Wauwatosa
Danziger, Lewis, Milwaukee
Davidoff, I. Z., Milwaukee
Demeter, N. D., Milwaukee
Derse, F. R., Milwaukee
Dettmann, N. F., Wauwatosa
Diamond, C. O., Milwaukee
Dier, P. C., Milwaukee
Dieterle, J. O., Milwaukee
Dix, C. R., Milwaukee
Dockry, L. E., Shorewood
Drew, F. E., Milwaukee
Dundon, G. A., Milwaukee
Dundon, J. R., Milwaukee
Dunst, C. G., Milwaukee
Dvorak, H. J., Milwaukee
Eberbaeh, C. W., Milwaukee
Echols, C. M., Milwaukee
Edelman, E. B., Milwaukee
Egan, W. J., Milwaukee
Eisenberg, Ed., Milwaukee
Eisenberg, J. J., Milwaukee
Eisenberg, L. A., Milwaukee
Eisenberg, P. J., Milwaukee
Epperson, P. S., Milwaukee
Enright, J. A., Milwaukee
Evans, C. A., Milwaukee
Evans, E. P., Milwaukee
Fabric, B. L., Milwaukee
Falk, V. S., Milwaukee
Farrell, H. J., Milwaukee
Federspiel, M. M., Milwaukee
Feld, D. D., Wauwatosa
Feld, S. M., Milwaukee
Feldt, R. H., Milwaukee
Fellman, G. H., Milwaukee
Fellows, R. M., Wauwatosa
Fernan–Nunez, M., Milwaukee
Fetherston, J. P., Milwaukee
Fidler, Charles, Milwaukee
Fifrick, L. L., Wauwatosa
Fisher, L. M., Milwaukee
Fitzgerald, G. F., Milwaukee
Fitzgerald, R. E., Milwaukee
Flaherty, G. S., Milwaukee
Foerster, H. R., Milwaukee
Foerster, O. H., Milwaukee
Fons, J. M., Milwaukee
Ford, W. B., Milwaukee
Forman, Judson, Milwaukee
Fortier, C. A., Milwaukee
Fox, M. S., Milwaukee
Franklin, I., Milwaukee
Frawley, D. D., Milwaukee
Frederick, R. H., West Allis
Froede, H. E., Milwaukee
Froelich, J. A., Milwaukee
Gabor, M. E., Milwaukee
Garland, J. G., Milwaukee
Garry, M. W., Milwaukee
Garvey, J. L., Milwaukee
Gates, J. F., Wauwatosa
Geiger, S. G., Milwaukee
Gertenbach, E. O., Milwaukee
Gilehrist, R. T., Milwaukee
Gilmer, L. T., Milwaukee
Gliseh, W. P., Milwaukee
Goldberger, W. W., Wauwatosa
Gorder, A. C., Milwaukee
Gordon, J. S., Milwaukee
Gramling, J. J., Milwaukee
Gramling, H. J., Milwaukee
Gray, A. W., Milwaukee
Greenberg, A. I., Milwaukee
Greenthal, R. M., Milwaukee
Griffith, J. C., Milwaukee
Grill, John, Milwaukee
Grob, A. R., Milwaukee
Grossmann, L. L., Milwaukee
Grotjan, W. F., Milwaukee
Grove, W. E., Milwaukee
Gudex, V. A., Milwaukee
Guerin, L. H., Milwaukee
Guy, E. F., Milwaukee
Habbe, J. E., Milwaukee
Haessler, F. H., Milwaukee
Hake, C. B., Milwaukee
Hall, R. M., Milwaukee
Hankwitz, A. W., Milwaukee
Hanley, W. J., Milwaukee
Hansen, J. W., Milwaukee
Hansmann, G. H., Milwaukee
Harder, H., Milwaukee
Harrington, E. T., Milwaukee
Harrington, T. L., Milwaukee
Haushalter, L. E., Milwaukee
Heeb, H. J., Milwaukee
Hefke, H. W., Milwaukee
Heidner, F. C., Milwaukee
Heifetz, E. C., Milwaukee
Heinan, F. C., West Allis
Heipp, E. A., Milwaukee
Heise, H. A., Milwaukee
Heraty, J. A., Milwaukee
Herner, W. L., Milwaukee
Hermann, A. H., Milwaukee
Hershberg, R. A., Wauwatosa
Hertel, A. J., Milwaukee
Herzog, J. V., Milwaukee
Hipke, G. A., Milwaukee
Hipke, L. W., Milwaukee
Higgins, S. G., Milwaukee
Hirseh, L. H., West Allis
Hoermann, B. A., Milwaukee
Hoffman, G. H., West Allis
Hoffman, J. G., Hartford
Hofmeister, F. J., Milwaukee
Hood, A. J., Milwaukee
Howard, M. Q., Wauwatosa
Howard, T. J., Milwaukee

Huber, H. H., Milwaukee
Huth, E. P., Santa Barbara
Irwin, Robert, Milwaukee
Jackson, Edward, Milwaukee
Jacobson, E. B., Milwaukee
Jekel, J. M., Milwaukee
Jenner, J. A., Milwaukee
Jermain, W. M., Milwaukee
Johnson, A. W., Hales Corners
Johnson, Frances, Milwaukee
Judge, T. A., Milwaukee
Jurishica, A. J., Milwaukee
Karr, J. K., Milwaukee
Kash, S. H., Cudahy
Kassowitz, K. E., Wauwatosa
Kastner, A. L., Milwaukee
Kay, E. M., Milwaukee
Kearns, W. M., Milwaukee
Keenan, L. J., Milwaukee
Kelly, G. F., Milwaukee
Kettelhut, E. J., Milwaukee
Kilkenny, G. S., Milwaukee
King, J. M., Milwaukee
Kilian, A. D., Milwaukee
Kissling, A. C., Milwaukee
Klein, J. T., Milwaukee
Kleinboehl, J. W., Milwaukee
Kleis, W. J., Milwaukee
Klumb, M. G., Milwaukee
Knox, Lawrence, Milwaukee
Knudson, A. H., Milwaukee
Koehler, J. P., Milwaukee
Kohn, S. E., Milwaukee
Kovacs, Arthur, Milwaukee
Kozina, F. J., Milwaukee
Kozina, V. J., Milwaukee
Kradwell, W. T., Wauwatosa
Kretchmar, L. H., Milwaukee
Kretchmar, Morris, Milwaukee
Kritjanson, H. T., Milwaukee
Kritter, F. J., Milwaukee
Kriz, G. A., Milwaukee
Krueger, B., Cudahy
Krumbiegel, E. R., Milwaukee
Krygier, W. L., Milwaukee
Krzysko, S. L., Milwaukee
Kuhn, H. J., Milwaukee
Kuhn, M. J., Milwaukee
Kult, A. S., Milwaukee
Kustermann, A. F., Milwaukee
Lademan, O. E., Milwaukee
Ladewig, A. W., Milwaukee
Ladewig, Harry, Milwaukee
Lahmann, Albert, Milwaukee
Lando, D. H., Jr., Milwaukee
Landsberg, Manfred, Cudahy
Lang, V. F., Milwaukee
Lee, P. A., Milwaukee
Leitsh, G. W., Milwaukee
Letterberger, J., Milwaukee
Lewis, Marian, Milwaukee
Liefert, W. C., Milwaukee
Lodedan, E. T., Milwaukee
Long, C. W., Milwaukee
Lotz, Oscar, Milwaukee
Loughlin, D. M., Milwaukee
Ludden, J. B., Milwaukee
Lungmus, B. A., Milwaukee
MacInnis, F. E., Milwaukee
MacKedon, W. L., Milwaukee
Mackoy, F. W., Milwaukee
MacRae, M. F., Milwaukee
Madison, F. W., Milwaukee
Magna, Salvatore, Milwaukee
Malnekoff, B. J., Milwaukee
Malone, J. Y., Milwaukee
Margoles, F. C., Milwaukee
Margoles, Milton, Milwaukee
Marquardt, C. R., Milwaukee
Ma.kson, S. M., Milwaukee
Martin, H. G., Milwaukee
Mason, E. W., Milwaukee
McBeath, N. E., Milwaukee
McCabe, John, Milwaukee
McCann, Edith, Milwaukee
McCormick, T. F., Milwaukee
McDonald, C. F., Milwaukee
McDonald, R. E., Milwaukee
McKillip, W. J., Milwaukee
McMahon, F. B., Milwaukee
McMahon, H. O., Milwaukee
McMurry, O. H., Greendale
McNary, J. F., Milwaukee
Melamed, Abraham, Milwaukee
Merten, A. N., Milwaukee
Miller, E. W., Milwaukee
Miller, H. L., Milwaukee
Mitchell, S. R., Milwaukee
Mollinger, S. M., Milwaukee
Molsberry, J. M., Milwaukee
Montgomery, R. P., Milwaukee
Morgan, S. E., Milwaukee
Morter, R. E., Milwaukee
Morton, S. A., Milwaukee
Munkwitz, F. H., Milwaukee
Murphy, F. D., Milwaukee
Murphy, J. A., Milwaukee
Murphy, W. J., Milwaukee
Nelson, W. V., Milwaukee
Neville, Mary, Milwaukee
Nichols, C. H., Milwaukee
Northey, T. M., Milwaukee
Oberbreckling, P. E., Milwaukee
Oberfeld, H. H., Milwaukee
O'Donovan, T. W., Milwaukee
O'Hara, J. J., Milwaukee
Ohlsen, M. P., West Allis
O'Leary, E. B., Milwaukee
Olson, H. J., Milwaukee
O'Malley, T. S., Milwaukee
Osgood, C. W., Wauwatosa
Oswald, F., Milwaukee
Ozonoff, J. B., Milwaukee
Pallasch, F. J., Milwaukee
Partridge, C. D., Cudahy
Patek, A. J., Milwaukee
Paulbeck, T. M., Milwaukee
Pegram, J. W., Milwaukee
Perlson, P. H., Milwaukee
Peters, L. M., Milwaukee
Piaskoski, Ray, Louisville, Ky.
Pink, J. J., Milwaukee
Plahner, Samuel, Milwaukee
Pleyte, A. A., Milwaukee
Pollack, S. K., Milwaukee
Popp, Albert, Milwaukee
Powers, H. W., Milwaukee
Pugh, G. J., Milwaukee
Purtell, R. F., Milwaukee
Purtell, P. J., Milwaukee
Quick, A. J., Milwaukee
Quick, E. W., Milwaukee
Regan, J. R., Milwaukee
Reifenrath, I. B., Milwaukee
Reinke, C. C., Milwaukee
Rhea, C. W., Wood
Rich, G. J., Milwaukee
Rice, E. M., Milwaukee
Rice, R. L., Milwaukee
Rikkers, D. F., Milwaukee
Ringo, H. F., Milwaukee
Robbins, J. M., Milwaukee
Robinson, H. P., Milwaukee
Roby, H. S., Milwaukee
Rosenthal, Samuel, Milwaukee
Rogers, E. H., Milwaukee
Rowan, J. P., Milwaukee
Ruschhaupt, L. F., Milwaukee
Russell, R. J., Milwaukee
Ruppenthal, A. J., Milwaukee
Sadoff, H. B., Milwaukee
Saketos, T. P., Milwaukee
Salinko, S. S., Milwaukee
Sander, O. A., Milwaukee
Sargeant, H. W., Wauwatosa
Savage, G. T., Milwaukee
Schacht, W. J., Milwaukee
Schade, R. E., Milwaukee
Schaefer, A. A., Milwaukee
Schelble, E. J., Milwaukee
Schelble, J. P., Milwaukee
Schlaepfer, K., Milwaukee
Schlomovitz, B. H., Milwaukee

Schlomovitz, E. H., Milwaukee
Schlossmann, B., Milwaukee
Schlueter, U. A., Milwaukee
Schmidt, H. G., Milwaukee
Schmidt, J. A., Milwaukee
Schmit, Felix, Milwaukee
Schneider, C. C., Milwaukee
Schoen, C. M., Milwaukee
Schoenkerman, B. B., Milwaukee
Scholter, E. A., Milwaukee
Schoofs, O. P., Milwaukee
Schowalter, R. P., Milwaukee
Schroeder, H. T., Milwaukee
Schroeder, J. C., Milwaukee
Schuler, F. X., Milwaukee
Schulz, Irwin, Milwaukee
Schumacher, H. S., Milwaukee
Schumm, H. C., Milwaukee
Schutte, A. G., Milwaukee
Schwartz, A. B., Milwaukee
Schweiger, L. R., Milwaukee
Scollard, W. J., Milwaukee
Selle, F. S., Milwaukee
Servis, L. T., Milwaukee
Seymer, L. A., Wauwatosa
Shaiken, Joseph, Milwaukee
Shaner, G. O., Milwaukee
Shapiro, A. M., Milwaukee
Sherwood, M. W., Milwaukee
Shumate, J. K., Milwaukee
Shutkin, M., Milwaukee
Slutzky, Nathan, Milwaukee
Smith, J. W., Milwaukee
Smith, L. D., Milwaukee
Smits, R. H., West Allis
Smuckler, R. H., Milwaukee
Spilberg, S. B., Milwaukee
Spitz, M. M., Milwaukee
Sproule, R. P., Milwaukee
Squier, T. L., Milwaukee
Stamm, L. P., Milwaukee
Steele, J. D., Jr., Milwaukee
Stern, C. S., West Allis
Stockinger, R. E., Milwaukee
Stranberg, W. L., West Allis
Stratton, F. A., Milwaukee
Tabachnick, H., Milwaukee
Tallmadge, G. K., Milwaukee
Taube, E. L., Milwaukee
Taugher, V. J., Milwaukee
Taylor, J. G., Milwaukee
Tegtmeyer, G. F., Milwaukee
Tessier, A. F., Milwaukee
Thill, G. E., Milwaukee
Toenhart, O. E., Milwaukee
Tolan, T. L., Milwaukee
Treskow, F. G., Milwaukee
Truitt, J. W., Milwaukee
Tufts, Millard, Milwaukee
Unger, A. A., Milwaukee
Urdan, B. E., Milwaukee
Van Hecke, L. J., Milwaukee
Verch, L. H., Milwaukee
Wagner, P. C., Milwaukee
Waldman, I. J., Milwaukee
Walker, L. J., Milwaukee
Walton, W. B., Milwaukee
Warner, R. C., Milwaukee
Warschauer, Bruno, Milwaukee
Washburn, R. G., Milwaukee
Waxman, S. I., Milwaukee
Wegmann, N. J., Milwaukee
Weisfeldt, L. A., Milwaukee
Weingart, W. F., Milwaukee
Wenstrand, D. E., Milwaukee
Whalen, G. E., Milwaukee
Wick, Samuel, Jefferson Barracks
Wiese, M. E., Milwaukee
Wild, J. P., Milwaukee
Willett, Thomas, West Allis
Winnemann, W. J., Milwaukee
Witte, D. H., Milwaukee
Wolf, R. C., Hales Corners
Wolter, S. H., Milwaukee
Yaffe, Aaron, Milwaukee
Young, A. F., Milwaukee
Ziegler, L. H., Wauwatosa
Zmyslony, W. P., Milwaukee
Zillmer, H. J., Milwaukee
Zivnuska, J. F., Milwaukee
Zuercher, J. C., Milwaukee

Monroe

Allen, J. S., Norwalk
Beebe, D. C., Sparta
Winter, A. E., Tomah

Oconto

Berg, W. R., Gillett
Kwapy, C. R., Oconto
Slaney, A. F., Oconto

Oneida

Bump, W. S., Rhinelander
Cline, F. A., Rhinelander

Outagamie

Bolton, E. L., Appleton
Brooks, E. H., Appleton
Carlson, G. W., Appleton
Frawley, W. J., Appleton
Gallaher, D. M., Appleton
Harrington, W. J., Appleton
Hegner, G. T., Appleton
Hittner, V. J., Seymour
Huberty, F. J., Appleton
Krueger, E. N., Appleton
MacLaren, J. B., Appleton
McGrath, E. F., Appleton
Marshall, V. F., Appleton
Mielke, E. F., Appleton
Neidhold, Carl, Appleton
Pardee, C. A., Appleton
Rector, A. E., Appleton
Taylor, A. C., Appleton
Towne, W. H., Hortonville
Zeiss, E. J., Appleton

Ozaukee

Balkwill, C. A., Grafton
Barr, A. H., Port Washington
Blanchard, P. B., Cedarburg
Drissen, W. H., Port Washington
Hurth, O. J., Cedarburg
Kauth, C. P., Port Washington
Scholz, H. F., Thiensville

Pepin

Bryant, G. E., Pepin

Pierce

Davee, Chalmer, Great Lakes
Dawson, C. A., River Falls

Polk

Arveson, R. G., Frederic
Noyes, G. B., Centurla
Simenstad, L. O., Osceola

Portage

Anderson, H. A., Stevens Point
Crosby, E. P., Stevens Point
Dunn, A. G., Stevens Point
Slater, R. H., Stevens Point
Wisiol, Erich, Stevens Point

Price

Leahy, J. D., Park Falls

Racine

Adamski, A. W., Racine
Bennett, J. F., Burlington
Brehm, H. G., Racine
Browne, C. F., Racine
Buckley, W. E., Racine
Christensen, F. C., Racine
Constantine, C. E., Racine
Dietz, R. J., Waterford
Dockery, G. A., Franksville
Fazen, L. E., Racine
Hahn, P. R., Racine
Hemmingsen, T. C., Racine
Henken, J. F., Racine
Hogan, J. H., Racine
Jamieson, R. D., Racine
Jones, B. O., Racine
Keland, H. B., Racine
Konnak, W. F., Racine
Kurten, R. M., Racine
Lindner, A. M., Racine
Mastalir, L. O., Burlington
McCracken, R. W., Union Grove
Marek, F. B., Racine
Miller, H. C., Racine
Pope, F. W., Racine
Roth, W. C., Racine
Schacht, E. W., Racine
Schacht, R. J., Racine
Schaefer, C. O., Racine
Schenkenberg, G. E., Racine
Schneller, E. J., Racine
Schulz, G. J., Union Grove
Thompson, I. F., Racine
Tucker, I. N., Racine
Walter, G. W., Racine
Wier, F. A., Racine

Richland
Brown, R. J., New Mexico
Bischof, H. F., Richland Center
Housner, R. E., Richland Center
Parke, George, Viola
Pippin, B. I., Richland Center

Rock
Allen, Jessie, Beloit
Allen, W. J., Beloit
Carney, C. M., Beloit
Clark, W. T., Janesville
Crosley, G. E., Milton
Fosse, Benjamin, Beloit
Frechette, F. M., Janesville
Friend, L. J., Beloit
Friske, O. W., Beloit
Gilbertsen, C. R., Janesville
Guilfoyle, J. P., Evansville
Gunderson, R. H., Beloit
Hatfield, M. E., Janesville
Johnson, W. L., Janesville
Kasten, H. E., Beloit
Kishpaugh, H. W., Beloit
Koch, V. W., Janesville
Metcalf, G. S., Janesville
Munn, W. G., Janesville
Pember, A. H., Janesville
Snodgrass, T. J., Janesville
Sorkin, S. S., Evansville
Springberg, J. C., Beloit
Sumner, W. C., Egerton
Van Kirk, F. W., Janesville
Vogel, T. L., Milton Junction

Rusk
Baker, J. C., Hawkins
Smith, Woodruff, Ladysmith
Whalen, M. L., Benco

Sauk
Buckley, T. J., North Freedom
Cahoon, Roger, Baraboo
Cox, L. M., Baraboo
Edwards, A. C., Baraboo
Irwin, H. J., Baraboo
Jewell, E. L., Loganville
Moon, J. F., Baraboo
Pawlisch, O. V., Reedsburg
Pearson, C. R., Baraboo
Pope, C. B., Baraboo
Randall, E. M., Prairie du Sac
Vander Kamp, Harry, Baraboo

Sawyer
Wesche, G. E., Hayward

Shawano
Bauer, Frederick, Shawano
Cantwell, A. A., Shawano
Gates, A. J., Tigerton
Peterson, L. W., Shawano
Terlinden, J. H., Bonduel

Sheboygan
Brickbauer, A. J., Plymouth
Deicher, H. F., Plymouth
Eigenberger, F., Sheboygan
Gruenwald, Ludwig, Sheboygan
Gunther, T. J., Sheboygan
Hansen, H. J., Sheboygan Falls
Hildebrand, G. J., Sheboygan
Juckem, G. J., Sheboygan
Knauf, A. J., Sheboygan
Malloy, T., Random Lake
Mason, P. B., Sheboygan
Meier, W. G., Jr., Sheboygan
Mueller, J. F., Plymouth
Naylen, F. J., Adell
Nause, F. A., Sheboygan
Neu, V. F., Sheboygan
Neumann, W. H., Sheboygan
Radloff, A. C., Plymouth
Russell, J. A., Random Lake
Sieker, A. W., Plymouth
Stannard, G. H., Sheboygan
Schmitt, A. J., Sheboygan
Van Altena, L. A., Cedar Grove
Van Zanten, W. W., Sheboygan
Weber, C. J., Sheboygan
Yoran, C. M., Plymouth

St. Croix
Epley, O. H., New Richmond
Newton, J. E., Hudson

Taylor
Elvis, E. B., Medford
Norton, D. M., Medford

Trempealeau
Alvarez, R. L., Galesville
Comstock, Elizabeth, Arcadia
Dockendorff, B. C., Camp McCoy
Jegi, H. A., Galesville
MacCornack, R. L., Whitehall
Weber, F. T., Arcadia

Vernon
Devine, G. C., Ontario
Trowbridge, W. M., Viroqua
Willstead, O. D., Hillsboro

Walworth
Coon, W. W., Walworth
Halsey, R. C., Lake Geneva
Kenney, H. J., Delavan
Meany, S. G., East Troy
O'Leary, T. J., East Troy
Soronson, E. D., Elkhorn
Wiswell, C. Y., Williams Bay

Washington
Bauer, K. T., West Bend
Edwards, R. G., Kewaskum
Fisher, R. S., Allenton
Hoffmann, J. G., Hartford
Kauth, P. M., West Bend
Kern, T. J., Richfield
Lehmann, F. W., Hartford
Lynch, H. M., West Bend

Waukesha
Barnes, H. T., Delafield
Burkhardt, E. W., Menomonee Falls
Campbell, W. B., Waukesha
Christiansen, James Waukesha
Dancey, R. F., Statesan
Davies, Gwilym, Waukesha
Davies, R. E., Waukesha
Domann, W. G., Menomonee Falls
Egloff, L. W., Pewaukee
Grover, F. L., Hartland
Hassall, J. C., Oconomowoc
Lando, D. H., Waukesha
Love, G. R., Oconomowoc
Nammacher, T. H., Oconomowoc
Sanford, L. L., Statesan
Schmidt, R. H., Statesan
Stemper, I. T., Oconomowoc
Tibbitts, U. J. Waukesha
Van Valin, E. C., Sussex
Voellings, W. J., Mukwonago
Wilkinson, J. F., Oconomowoc
Wilkinson, M. R., Oconomowoc
Woodhead, F. J., Waukesha
Zietlow, F. G., Waukesha

Waupaca
Boudry, M. O., Waupaca
Christofferson, A. M., Waupaca
Dernbach, G. P., New London
Hafemeister, E. F., Waupaca
Irvine, R. K., Manawa
Miller, E. A., Clintonville
Schmallenberg, H. C., New London
Van Schaick, R. E., Marion

Waushara
Hadden, S. L., Wild Rose

Winnebago
Anderson, G. R., Neenah
Beatty, S. R., Oshkosh
Beglinger, H. F., Neenah
Brown, R. C., Neenah
Brunckhorst, F. O., Neenah
Clark, W. E., Oshkosh
Connell, F. G., Oshkosh
Danforth, Q. H., Oshkosh
Hawbrick, H. J., Oshkosh
Helmes, L. O., Oshkosh
Hogan, J. M., Oshkosh
Hughes, B. J., Winnebago
Hugo, D. G., Oshkosh
Kilkenny, T. E., Winneconne
Koehler, A. G., Oshkosh
Lockhart, J. W., Oshkosh
Lowe, R. C., Neenah
O'Brien, P. T., Menasha
Pfefferkorn, E. B., Oshkosh
Pitz, M. H., Neenah
Quade, R. H., Neenah
Romberg, H. A., Oshkosh
Smith, L. M., Oshkosh
Smith, T. D., Neenah
Steen, M. H., Oshkosh
Wagner, R. F., Oshkosh
Wagner, W. A., Oshkosh
Williamson, G. H., Neenah

Wood
Barnet, E. G., Wisconsin Rapids
Bennett, L. J., Wisconsin Rapids
Beyer, Hart, Pittsville
Copps, L. A., Marshfield
Doege, K. H., Marshfield
Doege, P. F., Marshfield
Mason, R., Marshfield
Nelson, W. L., Wisconsin Rapids
Pomainville, H. G., Nekoosa
Pomainville, L. G., Wisconsin Rapids
Wickham, J. M., Marshfield

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THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. H. E. Twohig, Fond du Lac, President
Mrs. L. H. Lokvam, Kenosha, President-elect
Mrs. F. A. Douglas, La Crosse, Vice-president
Mrs. H. J. Hansen, Sheboygan Falls, Recording Secretary
Mrs. L. J. Keenan, Fond du Lac, Corresponding Secretary
Mrs. N. A. Hill, Madison, Treasurer
Mrs. R. E. Fitzgerald, Wauwatosa, Parliamentarian

COMMITTEE CHAIRMEN

Archives—
Mrs. J. E. Twohig, Fond du Lac

Finance—
Mrs. C. D. Partridge, Cudahy

Hygeia—
Mrs. A. W. Adamski, Racine

Philanthropic—
Mrs. P. J. Clark, Fond du Lac

Press and Publicity—
Mrs. A. A. Quisling, Madison

Program—
Mrs. H. O. Zurheide, Milwaukee

Public Relations
Mrs. E. P. Bickler, Milwaukee

Legislation (special committee)—
Mrs. C. N. Neupert, Madison

Circulation of Bulletin (special committee)—
Mrs. J. C. Fox, La Crosse

War Participation (special committee)—
Mrs. A. J. McCarey, Green Bay

Wartime Auxiliary Meeting An Outstanding Success

Mrs. H. E. Twohig Inducted As President; Mrs. L. H. Lokvam Named President-elect

AT THE fifteenth annual meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin on September 12, 13 and 14, Mrs. L. H. Lokvam of Kenosha was named president-elect; Mrs. F. A. Douglas of La Crosse, vice-president; Mrs. H. J. Hansen of Sheboygan Falls, recording secretary; and Mrs. N. A. Hill of Madison, treasurer.

Registration was slightly lower than in former years, but registrants voted it one of the most successful conventions ever held. Many factors contributed to this success. Despite rationing, food and service were excellent; the holding of all sessions at the Hotel Schroeder allowed members more time to meet old and new friends; each committee chairman and participant carried her responsibilities most efficiently; speakers and entertainers measured up to expectations and, as one officer expressed it, "left us with a feeling that as an Auxiliary we are a vital force in the community and a very necessary adjunct to the medical profession."

At the preconvention meeting of the Board of Directors on Sunday evening, twenty-two state and three national board members were present. Reports of state officers and chairmen were read and discussed, and a new standing committee on War Participation was created to replace the special committee on War Activities. Mrs. A. J. McCarey of Green Bay, who was appointed to continue her work as chairman of this section, presented a most interesting report of more than 50,000 hours spent by members throughout the state in war activities.

Monday Morning Session

On Monday morning, the first general session was opened by Mrs. E. S. Schmidt, president. In the absence of Mrs. F. R. Janney, president of the Milwaukee Auxiliary, a message of welcome was given by the vice-president, Mrs. H. A. Heise. Mrs. H. E. Twohig responded and was at the same time introduced as president-elect. The president's report, and those of county presidents which followed, emphasized the extensive work members have been doing in war activities.

Highlight of the morning session was a talk by Mr. C. H. Crownhart, secretary of the State Medical Society, on activities of the state office. He briefly sketched his methods of meeting legislators and showed charts and pictorial material used in combating bills which would prove detrimental to the high type of medical care Wisconsin citizens receive at the present time. In closing, he urged his listeners to take an active interest in legislative and public health problems at all times and especially now when the time of the physician is so limited.

Tuesday Morning Session

At the Tuesday morning session, Mrs. C. D. Partridge, parliamentarian and executive secretary of the Wisconsin State Nurses Association, paid tribute to Mr. Crownhart and the work done at the Madison office. In her work with the Nurses Association, she has many direct contacts with the office of the State Society, and she spoke very forcefully of the manner in which the medical profession is being served there.

After a one o'clock luncheon in the Empire Room, members listened to a most friendly, forceful talk by Rear Admiral Ross T. McIntire, Surgeon General of the United States Navy. His detailed account of accomplishments in lifesaving by the Medical Corps of the Navy was inspiring and reassuring, especially to mothers and relatives of servicemen.

At the buffet supper and reception on Monday evening, members and many guests gathered to greet state and national officers of the Woman's Auxiliary. They were entertained by Ted Passaris, an accomplished young pianist, and by Miss Myra Peache, director of the Shorewood Players and Pabst Theater, Milwaukee. She gave a review of current New York and Chicago plays, some of which may be presented at the Pabst Theater during the current season. Mrs. E. J. Carey, national president, Mrs. Charles Fidler, national corresponding secretary, and Mrs. O. W. Friske, national program chairman, were honor guests at this function.

Mrs. H. E. Twohig of Fond du Lac was inducted as president on the last day of the meeting and was presented with a pin by Mrs. E. S. Schmidt, retiring president, in accordance with the custom established a year ago. Before relinquishing the gavel, Mrs. Schmidt introduced the newly elected officers who were named by the nominating committee and voted upon earlier in the day.

Appointments

Following the postconvention board meeting, Mrs. Twohig announced the following appointees for the next year:

Corresponding secretary:

Mrs. L. J. Keenan, Fond du Lac

Parliamentarian:

Mrs. R. E. Fitzgerald, Wauwatosa

Committee chairmen:

Archives—Mrs. J. E. Twohig, Fond du Lac
Bulletin—Mrs. J. C. Fox, La Crosse
Finance—Mrs. C. D. Partridge, Cudahy
Hygeia—Mrs. A. W. Adamski, Racine
Legislation—Mrs. C. N. Neupert, Madison
Organization—Mrs. A. H. Barr, Port Washington
Philanthropic—Mrs. P. J. Clark, Fond du Lac
Press and Publicity—Mrs. A. A. Quisling, Madison
Program—Mrs. H. O. Zurheide, Milwaukee
Public Relations—Mrs. E. P. Bickler, Milwaukee
War Participation—Mrs. A. J. McCarey, Green Bay

Tuesday Luncheon

Mrs. E. J. Carey of Milwaukee, national president, was the main speaker at the Tuesday luncheon in the Banquet Room. She had just returned from a speaking tour of auxiliaries in the western section of the United States, and she told of the specific program which is planned for the year. Being given a definite program for future activities contributed materially to the feeling by members that their annual meeting was indeed a satisfying one. It is planned that Mrs. Carey's message will be carried in a forthcoming issue of *The Journal.*

Also on the afternoon program appeared Mrs. Richard Tyrrell, who presented a group of songs, accompanied by Mrs. Joseph Tolan, and Miss Nancy Gray, commentator on Radio Station WTMJ. The latter told of recently visiting war plants in the West and of a trip through a Japanese camp. She charmed her audience with accounts of outstanding personalities she had met and then expressed the opinion that the women in the home really hold the balance of power in their hands.

Annual Dinner

The annual dinner on Tuesday night provided a fitting climax to convention activities of members of the Woman's Auxiliary. With their husbands and friends, they heard

the president of the American Medical Association, Dr. James E. Paullin, speak on "The Role of the Medical Profession in Planning for Post-War Service," and Lieutenant Colonel Walter B. Martin of the United States Army discuss "The American Doctor at War." Several Auxiliary officers were introduced at the speakers' table.

WISCONSIN'S THREE NATIONAL OFFICERS

MRS. E. J. CAREY
President

MRS. CHARLES FIDLER
Corresponding Secretary

MRS. O. W. FRISKE
Program Chairman

Address of 1943-1944 Auxiliary President

By MRS. H. E. TWOHIG
Fond du Lac

I ACCEPTED this office very reluctantly, for I felt that I was in no way qualified to take the place of Mrs. Layton who, with her experience in club work, would have been a much more capable president.

I realize that I have accepted a great responsibility, but I have been assured by those who have held office before me that you have always cooperated most willingly.

This assurance has given me courage for the undertaking, and I shall be grateful for your continued helpfulness.

With our country still at war, we find that more and more of our younger members have gone to join their husbands whenever possible, and many more are left at home with added cares and responsibilities.

Those of us who are left, and who can, will have to work harder to carry on what the Auxiliary has already begun. I think this year would be an opportune time for us to make a special effort to carry out one of the aims of our National Auxiliary, namely, to encourage friendliness among the families of our physicians. We should call on those members who are left alone and try to include them in our social affairs, especially in our smaller communities. We might also find time to remember those who have gone away with a greeting or message to let them know that they are not forgotten. I know this would be appreciated.

We are urged by the chairman of the War Participation program to assist in every way in the program which has been established by the American Medical Association. We must keep up our interest in health education. Our classes in nutrition will be more important than ever, as will the classes in first aid and Red Cross work.

As to plans for Auxiliary work for the coming year, Mrs. Eben Carey, the national

president, will be our guest speaker at the luncheon today. Her address will deal with the war participation program which is to be carried out by Auxiliaries throughout the country.

Since we in Wisconsin are honored by having one of our own members as national president, I feel that we should honor her by leading the way in the work which she has planned for us.

Report of the 1942-1943 Auxiliary President*

By MRS. E. S. SCHMIDT
Green Bay

MEMBERS of the Auxiliary and guests, it is my happy privilege to bid you welcome to the fifteenth annual meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin. To you I submit the following report.

With wartime restrictions of travel, gas rationing, and the problem of household help preventing the attendance of many of our members, it is a distinct pleasure to greet so many who have hurdled the handicaps.

For the second time in the fifteen years of the existence of the Auxiliary, we are honored by having one of our state members elected to the high office of president of the National Auxiliary. Mrs. Robert E. Fitzgerald first held the office, and in June of this year Mrs. Eben J. Carey was inducted into office. Mrs. Carey has chosen Mrs. Charles Fidler to be her corresponding secretary and Mrs. Oscar W. Friske as her program chairman on the National Board. We are honored in having as our guests during this convention Mrs. Carey, Mrs. Fidler, and Mrs. Friske, three members who have given years of efficient service to the work of the State Auxiliary. We bid you welcome and wish you success in your new fields of endeavor.

In addressing you this morning, I am conscious of the privilege we enjoy as citizens of this great country of ours in being permitted to assemble in convention during one of the most critical times in the history of our nation. Let us, therefore, in gratitude, concentrate our thoughts and efforts upon activities that will further the success and uphold the high morale of our gallant fighting men.

War Activities

Realizing that war work was taking precedence over every other interest, endeavoring to keep our county units intact, and effectively to carry out projects proposed at the postconvention board meeting, I appointed a state chairman of War Activities to direct and coordinate all war effort.

The chairman, Mrs. Arthur J. McCarey of Green Bay, early in October sent a letter to each county president urging the appointment of a county chairman of war activities and containing detailed information and direction in sixteen listed projects. Members were urged to keep a record of service hours, hoping at the end of a year to report a 100 per cent participation in the wartime emergency. Mrs. McCarey will report on the gratifying state-wide response.

Soon after the close of the convention last September, typed lists of state officers, chairmen of committees, and names of county presidents were sent to the national and state offices and to the county presidents.

Since the Handbook, sent to each county auxiliary last year by Mrs. Supernaw, defines clearly and simply the scope of the work, all chairmen were urged to study the duties of the office assumed and send to me promptly their resultant outline of work. Only two were received in the prescribed thirty-day limit.

On October 22, I addressed the members of the Brown–Kewaunee–Door County Auxiliary at a luncheon meeting in Green Bay. That evening I was a guest at a delightful

* Presented before the Fifteenth Annual Meeting of the Woman's Auxiliary to the State Medical Society of Wisconsin, Milwaukee, September, 1943.

dinner meeting of the Fond du Lac Auxiliary. Interest in the outlined plan of war activities resulted in the formation of two units within the auxiliary, one to make surgical dressings, another to make up a class in the study of nutrition. A member, Mrs. Connell, is chairman of Red Cross work in Fond du Lac County.

Meeting of National Board of Directors

Your president attended the midyear meeting of the national Board of Directors, held in Chicago on November 20. The report read by the national president, Mrs. Haggard, stressed the opportunity given us, as doctors' wives, to further in this war emergency our threefold responsibility—"first, to maintain our own health; second, to help maintain the health of the community in which we live; and third, to bolster the morale of every individual who happens to come within the scope of our influence." It was an inspiration to me to hear reports of work accomplished or planned in the various states. Mrs. Carey will discuss some of these plans in her address at Tuesday's luncheon meeting.

Membership Cards

At the postconvention board meeting, a committee was appointed to select the design for membership cards, have them printed and distributed to each of the 1,125 members of the State Auxiliary. In accordance with the action taken at the national convention in June, membership cards will hereafter be obtained from the national office, the same design to be used in every state.

Due to the resignation of the chairman of organization, Mrs. Friske, it became my pleasant duty to assist a group in Crawford County in the organization of a new auxiliary. To perfect the organization, a proposed constitution and by-laws which I compiled was sent as a guide, together with an outline of helpful steps in procedure. We bid a hearty welcome to the newest addition to our official family.

We regret to report the disbanding of the Wood County Auxiliary. We trust that when travel restrictions are removed, making meetings possible, we may welcome Wood County back into the fold.

Twenty-six members of the state Board of Directors attended the midwinter meeting on January 28 in Milwaukee, when the thermometer hovered between twelve and fourteen below zero. Two members of the national board, Mrs. Carey and Mrs. Fitzgerald, were honored guests. Mrs. G. E. Stoddart, state commander, discussed the program of the Women's Field Army for the Control of Cancer, urging our participation in the drive which was about to be launched. I am proud of the response made by many of our county groups. The president announced the appointment of Mrs. H. O. Zurheide as convention chairman. A resume of the meeting by the secretary, Mrs. Russell Kurten, was printed in *The Wisconsin Medical Journal* for March.

War Bond Sales

On March 4, I accepted an invitation to address the Winnebago County Auxiliary at a dinner meeting. In April, letters were sent to county presidents urging them to appoint a committee to sell bonds in the second war bond drive. In Brown County our auxiliary sold bonds amounting to $18,400. Your president serves on the Red Cross Committee for the Recruitment of Nurses in Brown County, also on the Community War Chest drives.

National Auxiliary Meeting

It was my privilege to attend the twenty-first annual meeting of the Woman's Auxiliary to the American Medical Association held in Chicago, June 7 to 9. The Wisconsin Auxiliary had a representation of seventeen members. According to the report given, thirty-eight states and the District of Columbia now have state auxiliaries, with a total paid membership of 25,127.

In the name of the Wisconsin Auxiliary, a bouquet of roses was presented to Mrs. Carey on her induction into office. My report of the convention was printed in the July issue of *The Wisconsin Medical Journal.*

On June 9, members of the Executive Board met in Milwaukee to choose a succes-

sor to our beloved president-elect, Mrs. Oliver M. Layton of Fond du Lac. Mrs. Layton found it impossible to continue in office following the sudden death of Dr. Layton in December. In accordance with the authority vested in the Executive Board, Mrs. Henry E. Twohig of Fond du Lac, a former State Board member and former president of our county auxiliary, was elected to fill the vacancy.

Preparations for this meeting were intrusted with confidence to our hostesses, the members of the Milwaukee County Auxiliary. To Mrs. Zurheide, convention chairman, and her committees we extend our grateful appreciation for the excellent arrangements made for our comfort and entertainment.

Pleasant thoughts mingle with sad ones as I relinquish my duties as your president. The task, at times arduous, has been compensated by many pleasant contacts and experiences. I deeply appreciate the splendid cooperation given me by the officers, state chairmen, and county presidents; in fact, I am indebted to the entire membership. I thank you for the honor conferred on me and pledge my best endeavors to further the future interests of the Auxiliary.

Registrants at Auxiliary Meeting

Ashland–Bayfield–Iron

Prentice, Mrs. J. W.
Smiles, Mrs. C. J.

Brown–Kewaunee–Door

Dana, Mrs. D. B.
Dockry, Mrs. L. E.
McCarey, Mrs. A. J.
McNevins, Mrs. E. S.
Michna, Mrs. C. T.
Minahan, Mrs. P. R.
Quigley, Mrs. L. D.
Schmidt, Mrs. E. S.
Wochos, Mrs. F. J.

Columbia–Marquette–Adams

Gillette, Mrs. H. E.
McNamara, Mrs. L. V.

Dane

Brindley, Mrs. B. I.
Campbell, Mrs. R. E.
Curreri, Mrs. A. R.
Hill, Mrs. N. A.
McCormick, Mrs. S. A.
Neupert, Mrs. C. N.
Schmidt, Mrs. E. R.
Sprague, Mrs. L. V.
Supernaw, Mrs. J. S.

Dodge

Federman, Mrs. E. H.

Fond du Lac

Connell, Mrs. J. P.
Gavin, Mrs. S. E.
Huebner, Mrs. J. S.
Keenan, Mrs. L. J.
McGauley, Mrs. Nora
Raymond, Mrs. R. G.
Twohig, Mrs. H. E.
Twohig, Mrs. J. E.
Walters, Mrs. D. N.
Yockey, Mrs. J. C.

Kenosha

Andre, Mrs. E. F.
Davin, Mrs. C. C.
Lokvam, Mrs. L. H.

La Crosse

Douglas, Mrs. F. A.
Fox, Mrs. J. C.
Reay, Mrs. G. D.
Seedorf, Mrs. E. E.

Manitowoc

Cary, Mrs. E. C.

Milwaukee

Ackerman, Mrs. J. S.
Adamkiewicz, Mrs. J. J.
Allebach, Mrs. H. K.
Barta, Mrs. E. F.
Baumle, Mrs. B. J.
Behnke, Mrs. E. J.
Bellehumeur, Mrs. C. E.
Belknap, Mrs. E. L.
Bickler, Mrs. E. P.
Borman, Mrs. M. C.
Bourne, Mrs. N. W.
Brunkhorst, Mrs. R. O.
Brussock, Mrs. W. A.
Brzezinski, Mrs. E. A.
Burgardt, Mrs. G. F.
Cannon, Mrs. H. J.
Carey, Mrs. E. J.
Champney, Mrs. R. D.
Cook, Mrs. H. E.
Couch, Mrs. T. T.
Dempsey, Mrs. G. P.
Dieterle, Mrs. J. O.
Dix, Mrs. C. R.
Dundon, Mrs. J. R.
Everts, Mrs. E. L.
Fellows, Mrs. R. M.
Fetherston, Mrs. J. P.
Fidler, Mrs. Charles
Fitzgerald, Mrs. G. F.
Foley, Mrs. L. J.
Fons, Mrs. J. W.
Fox, Mrs. G. W.
Frawley, Mrs. D. D.
Froelich, Mrs. J. A.
Fromm, Mrs. A. H.
Frederick, Mrs. R. H.
Gaenslen, Mrs. F. J.
Gebhard, Mrs. U. E.
Gilchrist, Mrs. R. T.
Gramling, Mrs. H. J.
Grill, Mrs. J. C.
Grob, Mrs. A. R. F.
Grotjan, Mrs. W. F.
Gumerman, Mrs. G.
Gumerman, Mrs. G. J.
Guy, Mrs. E. F.
Habeck, Mrs. E. F.
Heeb, Mrs. H. J.
Heidner, Mrs. F. C.
Heil, Mrs. J. V.
Heise, Mrs. H. A.
Hermann, Mrs. A. H.
Hoffmann, Mrs. G. H.
Hopkinson, Mrs. D.
Howard, Mrs. M.
Howard, Mrs. T. J.
Jackson, Mrs. Edward
Jekel, Mrs. J. M.
Jermain, Mrs. W. M.
Kindwald, Mrs. J. A.
Kozina, Mrs. F. J.
Kozina, Mrs. R. J.
Kretlow, Mrs. F. A.
Kruszewski, Mrs. J. L.
Kuhn, Mrs. Agatha
Kult, Mrs. A. S.
Lee, Mrs. P. A.
Lettenberger, Mrs. Joseph
Liefert, Mrs. C. A.
Liefert, Mrs. W. C.
Ludden, Mrs. J. B.
McCabe, Mrs. John
McDonald, Mrs. C. F.
McDonald, Mrs. R. E.
McKillip, Mrs. W. J.
Minahan, Mrs. J. R.
Mollinger, Mrs. S. M.
Murphy, Mrs. F. D.
Murphy, Mrs. W. J.
Northey, Mrs. T. M.
Osgood, Mrs. C. W.
Partridge, Mrs. C. D.
Peterson, Mrs. E. F.
Pfeil, Mrs. R. C.
Purtell, Mrs. P. J.
Regan, Mrs. Viola
Rettig, Mrs. Frank
Rettig, Mrs. Henry
Reuter, Mrs. M. J.
Ruppenthal, Mrs. A. J.
Schelble, Mrs. E. J.
Schowalter, Mrs. R. P.
Schubert, Mrs. F. J.
Sherwood, Mrs. M. W.
Sproule, Mrs. R. P.
Squier, Mrs. T. L.
Stamm, Mrs. L. P.
Stockinger, Mrs. R. E.
Studley, Mrs. William
Taylor, Mrs. J. G.
Thill, Mrs. G. E.
Tufts, Mrs. Millard
Uszler, Mrs. L. B.
Walton, Mrs. W. B.
Washburn, Mrs. R. G.
Witte, Mrs. D. H.
Wynegar, Mrs. D. E.
Ziegler, Mrs. L. H.
Zurheide, Mrs. H. O.

Outagamie

Carlson, Mrs. G. W.
Hegner, Mrs. G. T.
Neidhold, Mrs. C. D.
Rector, Mrs. A. E.
Zeiss, Mrs. E. J.

Polk

Arveson, Mrs. R. G.

Racine

Adamski, Mrs. A. W.
Albino, Mrs. J. M.
Browne, Mrs. C. F.
Dockery, Mrs. G. A.
Kurten, Mrs. R. M.
Pope, Mrs. F. W.

Rock

Frechette, Mrs. F. M.
Friske, Mrs. O. W.
Kasten, Mrs. H. E.
Snodgrass, Mrs. T. J.

Sauk
Edwards, Mrs. A. C.
Trautman, Mrs. Milton
Vander Kamp, Mrs. Harry

Sheboygan
Hansen, Mrs. H. J
Hildebrand, Mrs. G. J.
Radloff, Mrs. A. C.

Trempealeau–Jackson–Buffalo
McCornack, Mrs. R. L.

Walworth
Halsey, Mrs. R. C.
Sorenson, Mrs. E. D.

Washington–Ozaukee
Barr, Mrs. A. H.
Bauer, Mrs. K. T.
Blanchard, Mrs. P. B.
Fisher, Mrs. R. S.
Lynch, Mrs. H. M.
Monroe, Mrs. M. E.

Waukesha
Barnes, Mrs. H. T.
Hassall, Mrs. J. C.
Peters, Mrs. H. A.

Waupaca–Shawano
Irvine, Mrs. R. K.
Irvine, Mrs. W. J.
Miller, Mrs. E. A.

Winnebago
Anderson, Mrs. G. R.
Pfefferkorn, Mrs. E. B.
Smith, Mrs. T. D.
Wagner, Mrs. W. A.
Williamson, Mrs. G. H.

Guests
Baker, Mrs. R. G., Tomahawk
Borman, Mrs. G. T., Oshkosh
Bump, Mrs. W. S., Rhinelander
Duval, Mrs. C. L., Kewaunee
Edmonston, Mrs. C. C., Waukesha
Garding, Mrs. C. J., Jefferson
Grab, Mrs. J. A., Madison
Hewitt, Mrs. B. E., Milwaukee
Krüeser, Miss Bernadine, Gillette
Leahy, Mrs. J. D., Park Falls
Morris, Mrs. K. A., Merrill
Pember, Mrs. A. H., Janesville
Pierce, Mrs. D. F., Hales Corners
Schmidt, Mrs. E. C., Milwaukee
Shumate, Mrs. J. K., Madison
Stoddart, Mrs. G. E., Beaver Dam

IMPORTANT REMINDER

The bill calling for annual registration of physicians became a law of the State of Wisconsin on May 17, 1943. It states that "Every person licensed to and engaged in the practice of medicine and surgery, osteopathy, or osteopathy and surgery, in this state, shall, in the month of January of each year, register with the secretary of the Wisconsin state board of medical examiners, upon a form to be furnished by the board."

Sometime before the first of December of this year, you will receive a simple registration form from the secretary of the State Board of Medical Examiners. The fee for 1943 is $3.

Although the law states that the form must be returned during the month of January, do not put it off. Give it your immediate attention and aid in the prompt and effective administration of the annual registration law, sponsored and endorsed by the State Medical Society of Wisconsin, because:

1. It provides the only means by which a current and correct inventory of physicians in Wisconsin can be maintained.

2. Such an inventory will be of immeasurable value in assisting in the proper distribution of physicians, particularly as this problem becomes acute at the conclusion of the war.

3. By annual publication of a list of physicians, every law enforcement officer in the State of Wisconsin will know who is licensed to practice, and is practicing, in this state.

4. For the first time it will provide the State Board of Medical Examiners with a sum sufficient to enforce the Medical Practice Act and thus secure the elimination of the unlicensed quack and charlatan.

5. It has proven a highly satisfactory public health law in twenty-three states in which it is now operative.

IN APPRECIATION

To the personnel of the Milwaukee Auditorium and the Hotel Schroeder the State Medical Society of Wisconsin acknowledges and expresses its appreciation for the outstanding service afforded us during our recent meeting—services which were gladly and freely given "beyond the call of duty."

Both staffs include within their ranks individuals who through the years have given unstintingly of their time and effort that our meetings might be presented in an orderly and efficient manner.

Particular recognition is given to Mr. Conrad Doepke of the Hotel Schroeder, who, like the magician, is able to produce the impossible in comparatively the same time it takes the magician to extract a rabbit from a hat. To Miss Adelaide Stollenwerk, whose intimate surveillance of every detail gives assurance that every facility is in the right place at the right time, we extend our gratitude.

To "Al" Bowitz at the Milwaukee Auditorium likewise must be extended congratulations for his uninterrupted efficiency of the past several years despite adverse circumstances. When "Al" takes over, we experience the same feeling of confidence that everything will be all right as does the patient when he has selected the physician of his choice, confident in the knowledge that a thoroughly competent specialist is in command.

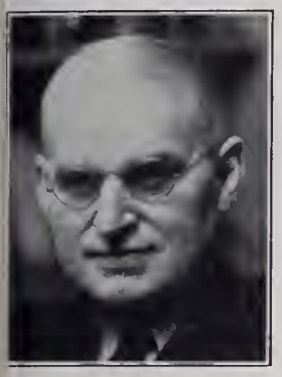
To Mr. Maas, manager of the Milwaukee Auditorium, and to Mr. Limecooley, manager of the Hotel Schroeder, the Society extends its sincere appreciation for their many acts of kindness and thoughtfulness performed for the convenience and comfort of the Society during the course of the meeting and through them extend to each member of their respective staffs our appreciation and thanks.

THE STATE MEDICAL SOCIETY OF WISCONSIN

News Items and Personals

Speaking on nervous diseases, *Dr. Lois Lobb*, Eau Claire, addressed members of the Exchange Club at their regular luncheon meeting on Monday, August 23.

—△—



E. R. SCHMIDT

On September 16, Acting Governor Walter S. Goodland appointed *Dr. Erwin R. Schmidt*, chief surgeon at the State of Wisconsin General Hospital, Madison, to the Soldiers Rehabilitation Board to succeed *Colonel William S. Middleton*, Madison, dean of the University of Wisconsin Medical School, now on leave of absence for service in the Army. The Board handles rehabilitation of World War I veterans under the adjutant general's office.

—△—

Dr. Victor Marshall, Appleton, discussed "The Meaning of Your Hands" at a joint meeting of the Rotary Club and the Lions Club, New London, on September 13. Dr. Marshall used illustrations to explain the significance of the shape of the hand.

—△—

Members of the Kiwanis Club, Wauwatosa, heard a discussion of "What to Do with the Tuberculosis Patient Who Will Not Accept Treatment" presented by *Dr. Anthony V. Cadden*, medical director of Muirdale Sanitarium, Wauwatosa.

—△—

Dr. Mead Burke, acting assistant superintendent and chief resident physician at the State of Wisconsin General Hospital, Madison, and Mr. Leo G. Schmelzer, administrative assistant, attended a convention of the American Hospital Association at Buffalo, New York, in September.

"The School Teacher and Public Health" was the subject of a talk presented by *Dr. Erwin C. Cary*, president of the Manitowoc County Health Officers' Association, before the annual meeting of the Manitowoc County teachers on August 28.

—△—

A course in occupational therapy leading to a Bachelor of Science degree was approved by the faculty of the University of Wisconsin, Madison, at its meeting on Monday, August 30. This new course, based upon already existing courses, was recommended by a special committee from the College of Letters and Science, the School of Education, and the School of Medicine for the establishment of a course of study for the training of occupational therapists.

—△—

The program committee of the American Academy of Ophthalmology and Otolaryngology met at Oconomowoc on July 31 for its midsummer conference. The purpose of the meeting was to outline the final details for the annual meeting of the Academy held in Chicago the early part of October. Besides drawing up the details for the convention, the committee made use of the recreational facilities offered by the Oconomowoc community.

—△—

Miss Gladys Ramsey, librarian of the Medical School Library and the Medical Library Service of the University of Wisconsin since 1932, resigned her position effective October 1. She will attend the Graduate Library School at the University of Chicago.

Mrs. Esther Merwin Goettling, who held the position of assistant librarian during the last three years, has succeeded Miss Ramsey as librarian.

—△—

Dr. William W. Kelly, Green Bay, was the principal speaker at the seventh annual teachers' institute of Brown County held at De Pere, Sept. 10.

SUGGESTION BOX

Tear out and mail to *The Wisconsin Medical Journal*, 917 Tenney Building, Madison (3), Wisconsin

I like the Military Notes section—let's have more ---------- ☐

Give us more "News of the Neighbors" ☐

We want more pictures ---------- ☐

Give us a humor column ---------- ☐

More scientific articles ---------- ☐

Any other suggestions ----------

Society Proceedings

Brown—Kewaunee—Door

The regular preconvention meeting of the Brown-Kewaunee-Door County Medical Society was held at the Beaumont Hotel, Green Bay, on September 9 at 6:30 p. m.

Douglas

Assemblyman Arthur A. Lenroot and William R. Foley addressed members of the Douglas County Medical Society at the Hotel Superior, Superior, on September 1. The subject of their discussion was "Medical Bills in the Legislature."

La Crosse

On September 7, the La Crosse County Medical Society held its monthly meeting and elected the following officers for 1944, all of La Crosse:

President—Dr. Paul C. Gatterdam
Vice-president—Dr. James C. Fox
Secretary-Treasurer—Dr. A. Jens Rosholt
Delegate—Dr. Frederick A. Douglas
Alternate—Dr. A. Jens Rosholt
Program Committee—Dr. Everett E. Seedorf, Dr. Alf H. Gundersen, Dr. Nels P. Anderson, Dr. James E. Heraty.

Outagamie

The September meeting of the Outagamie County Medical Society was held at the Riverview Country Club, Appleton, on Friday, September 24. The principal speaker was Dr. Carl S. Harper, Madison. A golf jamboree was held in the afternoon.

Sixth Councilor District

A preconvention parley in the form of a dinner meeting at the Conway Hotel, Appleton, August 24 was attended by delegates, presidents, and secretaries of Brown, Fond du Lac, Kewaunee, Outagamie, and Winnebago Counties. Mr. Charles H. Crownhart, secretary of the State Medical Society, was the speaker of the evening.

Coming Events

The Association of Military Surgeons of the United States

Representatives from fourteen foreign countries will attend the Fifty First Annual Convention of the Association of Military Surgeons of the United States, a great symposium on war medicine to be held at the Bellevue-Stratford Hotel in Philadelphia, on October 21, 22, and 23. The symposium, which will be of vital and direct interest to the health and welfare of the men in the armed forces, to physicians, research specialists and scientists everywhere, as well as to the general public, will chart the progress and the recent advances made in the care and hospitalization of men in the armed forces.

Officials of the convention expect an attendance of more than 2,000 physicians now attached to the armed forces here and abroad, as well as thousands of other physicians and medical men in civilian practice.

Examinations—American Board of Obstetrics and Gynecology

The next written examination and review of case histories (Part I) for all candidates will be held in various cities of the United States and Canada on Saturday, February 12, 1944, at 2:00 p. m. Candidates who successfully complete the Part I examination proceed automatically to the Part II examination held later in the year. All applications must be in the office of the Secretary by November 15, 1943.

All candidates are now required to have been out of medical school not less than eight years and in that time to have completed an approved one year interneship and at least three years of approved special formal training, or its equivalent, in the seven years following the intern year. This Board's requirements for interneships and special training are similar to those of the American Medical Association since the Board and the A. M. A. are at present cooperating in a survey of acceptable institutions. At the last Board meeting held in May, 1943, it was decided to give special credit for certain types of military service. All candidates must be full citizens of the United States or Canada before being eligible for admission to examinations.

All candidates will be required to take the Part I examination, which consists of a written examination and the submission of twenty-five case history abstracts, and the Part II examination (oral-clinical and pathology examination). The Part I examination will be arranged so that the candidate may take it at or near his place of residence, while the Part II examination will be held late in May, 1944, in that city nearest to the largest group of candidates. Time and place of this latter will be announced later.

For further information and application blanks, address Dr. Paul Titus, Secretary, 1015 Highland Building, Pittsburgh (6), Pennsylvania.

BIRTHS

A son to Dr. and Mrs. Conde F. Conroy, Milwaukee, on August 28.

DEATHS

Dr. Clarence A. Baer, 63, Milwaukee dermatologist, died late Wednesday, September 15, after an illness of more than a year.

Dr. Baer was born in Milwaukee. His parents came to this country from Germany in the early seventies. Dr. Baer attended the University of Wisconsin, Madison, and Johns Hopkins University, Baltimore, Maryland, and completed his medical studies in Paris, Vienna, and other European medical centers. Upon his return to this country, he began practicing in Milwaukee, specializing in skin diseases. At one time he was chief of staff at the Milwaukee Children's Hospital.

For many years Dr. Baer spent his summers in Paris, where he studied and lectured in dermatology at the Sorbonne. During World War I, he volunteered for service and served on the British and French fronts with the Red Cross. For heroic devotion to duty, he was awarded the medaille d'honneur, the Croix de guerre, the Medaille de la Reconnaisance francaise, and the Polish eagle.

He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

No immediate relatives survive him.

Dr. Haldor Barnes, 48, who was with the first Byrd expedition to the South Pole, died in Toledo, Ohio, on September 14. Until a few months before his death, he had been a practicing physician at Manitowoc. A graduate of the University of Copenhagen, Denmark, he was the only physician who accompanied Commander Byrd on his trip to the South Pole.

At the time of his death, he was a member of the Marinette–Florence County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors are his widow, a daughter, and a son in Toledo and his mother and two sisters in Denmark.

Dr. Julius H. Sure, 63, practicing physician in Milwaukee for the last forty years and a member of the staff of Mt. Sinai Hospital, Milwaukee, for the last thirty years, died Thursday evening, August 9, following a short illness. He was an obstetrician and gynecologist.

Born in Russia, Dr. Sure came to the United States fifty-two years ago. He was graduated from the University of Illinois College of Medicine, Chicago, and in 1926 took postgraduate work in Vienna. He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by a daughter, two grandchildren, two brothers, and three sisters.

Dr. G. A. Ritchie, 85, Appleton, died at his home on Friday, September 17, following a long illness. He had practiced medicine at Appleton since 1894. He attended Oshkosh State Teachers College and was graduated from Rush Medical College, Chicago, in 1886.

He was a member of the Outagamie County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Dr. Nicholas E. Hausmann, 68, Kewaskum, died of a heart ailment at his home on Monday, September 13. He had been ill for the last three years.

Born August 11, 1875, in Elmore, he moved with his parents to Kewaskum during his boyhood. He attended Mission House College and later was graduated from Rush Medical College, Chicago. He practiced medicine at Kewaskum from 1901 until the time of his illness.

At the time of his death, he was a member of the Washington–Ozaukee County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow, a daughter, two grandchildren, a sister, and two brothers.

Dr. Albert S. Thompson, Mt. Horeb, died Saturday, August 28, in a Madison hospital. He was born in Mt. Horeb in 1878. He obtained his medical education at the Minneapolis College of Physicians and Surgeons, from which he was graduated in 1902.

At the time of his death, he was a member of the Dane County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

His widow, two sons, and three daughters survive him.

Dr. Walter B. Williams, 71, practicing physician in Argyle during the last thirty-three years, died Sunday morning, September 5, while preparing to attend patients waiting in the anteroom of his office. His death was attributed to an attack of a heart ailment from which he had been suffering for the last twelve years.

Dr. Williams was born in New York in 1872. He was graduated from the Rush Medical College, Chicago, and practiced in Salem, Chicago, and Kenosha before moving to Argyle, where he practiced from October 12, 1910, until the time of his death.

He was a member of the Lafayette County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are a son, a sister, a niece, and a nephew.

Dr. W. Hiram Baldwin, Milwaukee, died in August at the age of 81. After practicing in Green Bay for ten years, he retired because of an injured

hand and had made his home in Milwaukee during the last thirteen years.

Born in Canada of American parents, he came with them to Wisconsin at the age of 8. He was a graduate of Rush Medical College, Chicago. Surviving him is his widow.

Dr. Anton Zeiss, 84, retired Sheboygan physician, died at his home in Sheboygan, August 28. A native of Langsuit, Germany, Dr. Zeiss came to Sheboygan in 1888, where he practiced medicine and served as both county and city physician. Mrs. Zeiss, who came from Germany with him, preceded him in death in 1921.

His only survivors are an adopted daughter and two grandchildren.

Dr. Frank G. Strayer, 74, Oshkosh, died at his home on September 15. He had been in failing health for the last four years and had been seriously ill since August 3.

Dr. Strayer was born December 19, 1868, at Freeport, Iowa, where he taught for several years before beginning his medical studies. He attended the University of Iowa and was graduated from Marion–Sims College of Medicine, St. Louis, in 1894. After practicing for less than a year at Grafton, Iowa, he moved to Spencer, Wisconsin, where he practiced until his retirement in 1906. He then resided in Omro for fourteen years before moving to Oshkosh.

Dr. Saxton J. Morgan, 78, retired Albany physician, died at his home on September 13. He had been ill for the last nine years and confined to his bed for two weeks.

He was a graduate of the Hahnemann Medical College and Hospital, Chicago, and served his internship in the Cook County Hospital, Chicago. Following graduation, he married a classmate, Dr. Lillie Martin. Together they practiced medicine in Albany for sixteen years and experienced all the hardships of the pioneer country physician.

Following his retirement from the profession of medicine, he devoted his time to the Albany Hardware Specialties Manufacturing Company, of which he was co-owner and founder.

His only survivor is his widow.

SOCIETY RECORDS

New Members

Donald E. Moore, Milwaukee.

F. G. Gaenslen, 1300 University Avenue, Madison.

Changes of Address

H. M. Klopf, Chelsea, Massachusetts, to 4419 West Lisbon Avenue, Milwaukee.

J. C. McCarter, Madison, to % Evanston Hospital Association, 2650 Ridge Avenue, Evanston, Illinois.

O. E. Toenhart, Cassville, to 2757 North 57th Street, Milwaukee.

H. W. Housley, Neillsville, to Mendota.

News of the Neighbors

Will There Be a Surplus of Physicians After the War?

"No doubt the above question has occurred to many thoughtful physicians and the answer must be hypothetical.

"Because of the long course in training, the difficulties of establishing a practice, and the intangibles connected with the maintenance of it, the years of economic security and productivity for a physician in private practice are very few. In spite of the fact that much is being said in the press and medical journals about the security of physicians at the present time, it would seem that most physicians are not too busy to be able to do good work and to do most of the things which they are requested to do. Actually it would seem that most physicians are quite happy to do just about what they are now doing, and many fear that the present pace will not be sustained after the present conflict is over. This all leads to the question of a surplus of physicians after the war.

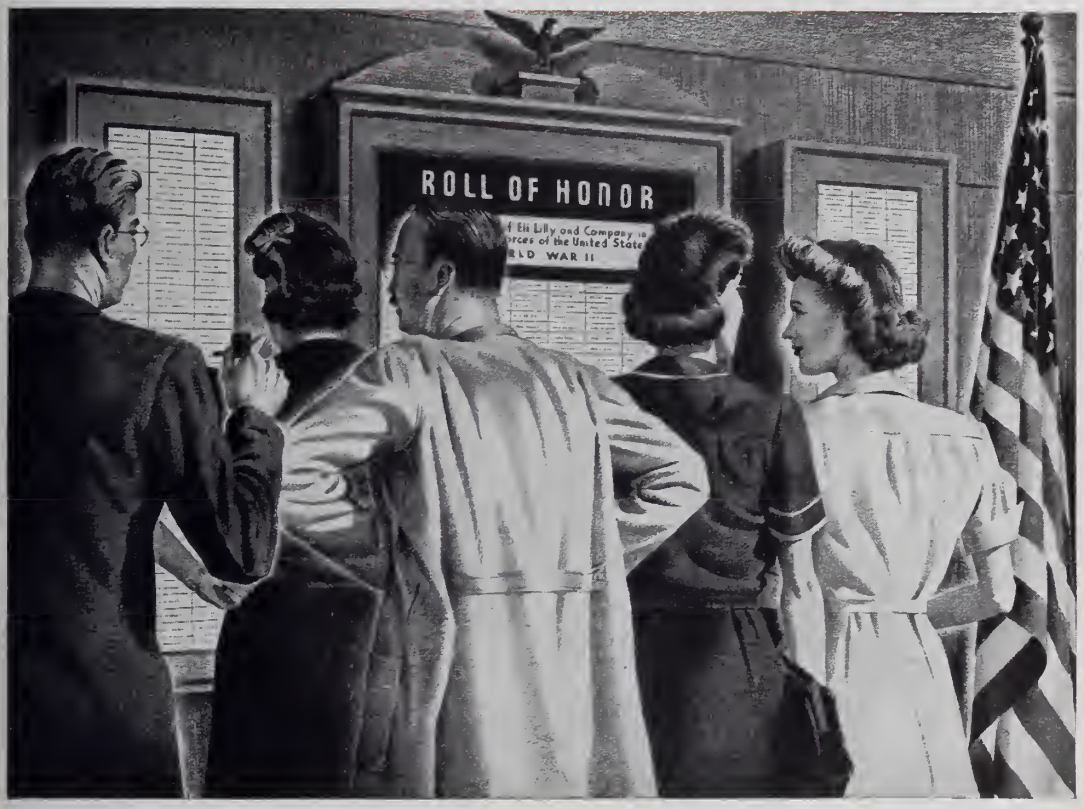
"At the present time no one can know what will be the demands of medicine after the present conflict. The armed forces may request many to remain in the service of the Government. If the social order of the United States and western civilization is to be the standard for the whole world, then our responsibilities will be great and the medical profession of the United States will be inadequate to supply the demands placed upon it.

"If such a Utopia should be possible after this conflict, we shall have to send physicians and scientists to all parts of the world, for they will have both the training and perspective to organize and lead in this move toward Utopia. The medical profession of the United States will be the only group of physicians where enough surplus exists to supply the universal demand for participation in a move for general enlightenment.

"If, after this conflict is over, people remain as they have always been, aggressive and selfish in a broad sense, then it will be necessary to maintain a large armed force and this force will have to be supplied with physicians, and many of the physicians will desire to stay in the armed services.

"The medical profession must be prepared to assume any responsibility which is placed upon it. Its responsibilities are to supply good medical services

Honor Roll



WAR DIPS DEEPLY into the world-wide family of Lilly men and women. Hundreds of them are faithfully serving in the armed forces of the allied nations. Those at home do their part, too, for essential drugs must be supplied in ever-increasing quantities for military and civilian use. Eli Lilly and Company honors those associates under arms and salutes those who carry on Lilly traditions of integrity in the manufacture of finest pharmaceuticals, be it in war or in peace.

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to all citizens with intelligence and integrity. Its own interest should be to maintain the standards which have been built up for it in the past and the services which the profession can render will be provided. The reward, as always, will be the satisfaction in a work well done.—R. W. M."—An editorial in the August 7, 1943, issue of *Philadelphia Medicine.*

The Soldier-Wife Obstetrical Care Plan

"To the Members of the Kansas Medical Society: The administration of any new organization or plan carries with it many debatable details. There has arisen out of the Children's Bureau, the soldier-wife obstetrical care plan. This was originally placed in the hands of our Committee on Maternal Welfare and they approved the plan in general, realizing that there were some details that would cause unrest among the hospitals and physicians. It would seem to me that as a profession, we should cooperate with this plan and do everything in our power to render a fine service to these soldier's wives. Since the care and delivery of these wives must come under the direct supervision of a medical physician, it is our duty to render a good service that will be a credit to the profession. At times the hospitals will be crowded to capacity and you will be unable to keep the case in the hospital the recommended ten days. With tact, each physician can handle the situation, with explanation of the problem. Sincerely, J. L. Lattimore, M. D., President, The Kansas Medical Society." From the President's Page of the July, 1943, issue of *The Journal of the Kansas Medical Society.*

An Enterprising Cabby

"There is at least one Washington taxi driver who is not letting 'the grass grow under his feet.' When he learned of the recent action taken by the Office of Price Administration to insure a sufficient supply of gasoline for doctors, he prepared and distributed the following letter to his passengers.

" 'Recent Press reports indicate that Senator McCarran is under the impression that local doctors need lots of gasoline to visit their patients.

" 'That is a joke. Local M.D.'s do very little visiting. The patients must come to them—even when they have broken limbs. How do they do it? Very simple—by taxicabs.

" 'During my 33 years of cab driving—in this city —I estimate that cabs have done at least 98 per cent of the ambulance work here. If a patient is able to hobble or crawl, he uses a cab to get medical attention. That is because the cab is the lowest price ambulance in the world. Therefore, I say the cabs should get a majority of people to get to a Doctor. He—in most cases—won't come to them.

" 'Now, O.D.T. must find a way to give local cabs —and even those in nearby Md. and Va.—at least 10 gallons of gas every 24 hrs., or the drivers will have to quit and take other jobs until the gas shortage has been solved. Such a shut down in cab service will leave people who use cabs to obtain medical attention, to catch trains and planes etc., in a desperate plight.'

"Well, the doctors aren't the only ones who have gasoline troubles!"—From the July, 1943 issue of *Medical Annals of the District of Columbia.*

CORRESPONDENCE

September 23, 1943

Mr. Charles Crownhart, Secretary
State Medical Society of Wisconsin
Tenney Building
Madison, Wisconsin
Dear Mr. Crownhart:

I want to thank you for extending the invitation to Mrs. Harper and myself to be guests of the State Medical Society at its banquet in Milwaukee September 14, 1943. I greatly appreciate, . . . the citation extended to me by the Medical Society of the state of Wisconsin through its officers and councillors. This is a great honor, and as far as I am able to ascertain the first occurrence of the kind happening in the United States where the medical association of any of the states extended to a state health officer its appreciation for the work that had been done in the field of public health.

Wisconsin again takes the lead in the close relationship that exists between the public health workers and the medical profession.

Appreciatingly yours,
(Signed) C. A. Harper, M. D.
Medical Specialist in Public Health

THE PRESS

Fatal Abortion Leads to Trial

"Charged with second degree manslaughter in connection with the abortion death of Miss Hazel Williamson, 34, of Waunakee, Wis., Dr. Edmund W. Timm, 68, of 2200 N. 3rd St., was bound over to municipal court for trial following a preliminary hearing in the district court Thursday afternoon.

"The state's chief witness was Mrs. Christine Schlabach, 2504 N. Sherman Blvd., who is charged as an accessory in the case. She formerly operated the rooming house at 2824 W. Highland Blvd., where Miss Williamson died at 1:05 a. m., June 15.

"Mrs. Schlabach said she telephoned Dr. Timm immediately after the woman's death, and that he arrived at the rooming house 15 minutes later.

"Dr. Timm then examined Miss Williamson and pronounced her dead, the witness said. She added that Dr. Timm then took Miss Williamson's purse into the kitchen and found in it a slip of paper with the names of Dr. Timm and two Chicago physicians. Dr. Timm tore off the portion bearing his name and then returned the purse to the death room, Mrs. Schlabach said.

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"Mrs. Schlabach said that Miss Williamson came to the rooming house first on June 10, following Dr. Timm's telephone call that he was sending a patient there for nursing care. By 'nursing care,' the witness said, was meant 'after a miscarriage.' Mrs. Schlabach said Dr. Timm treated Miss Williamson at the rooming house June 14.

"The other state witnesses were Dr. E. L. Tharinger, pathologist, who testified Miss Williamson's death was caused by an abortion, and Detective John Zilavy, who said Dr. Timm admitted he had received $150 from Miss Williamson as his medical fee."—From the August 13, 1943, issue of the *Milwaukee Journal.*

Trade News

Winthrop Prepares for Increased Production of Penicillin

Winthrop Chemical Company, Inc., today announced plans for a vast increase in the production of penicillin, new highly concentrated extract from common cheese mold which kills bacteria and which has proved to be rapidly curative in such diseases as blood stream infection, osteomyelitis, pneumonia and gonorrhea.

Additional facilities for the manufacture of this potent drug have been acquired in Rensselaer, N. Y., according to Dr. Theodore G. Klumpp, President, and will be devoted entirely to the manufacture of the drug which is now allocated exclusively to the Armed Forces. The War Production Board has granted high priority ratings for needed equipment, he said, and work is proceeding at all possible speed.

One of the first and today among the five largest producers of penicillin, Winthrop started to work with the drug in December, 1940, and is currently supplying millions of units weekly to the armed forces.

Continuous Caudal Analgesia in Obstetrics

Eli Lilly and Company, Indianapolis, announces the release of a 16 mm. silent motion picture in color on "Continuous Caudal Analgesia in Obstetrics." The film is available to physicians for showing before medical societies and hospital staffs. It deals with the history, anatomy, and physiology of caudal analgesia and demonstrates the technic of use in obstetrics.

The film was made at the U. S. Marine Hospital, Staten Island, New York, by authorization of the Surgeon General, U. S. Public Health Service, and the demonstrations were carried out by the originators of the technic, Dr. Robert A. Hingson and Dr. Waldo B. Edwards.

Winners in Schering Award Competition

Announcement of the winners in the Schering Award Competition of 1942 has been made by the Committee of Judges. The subject in the second competition of the Schering Award was "Endocrinology in War Medicine" or any of certain approved alternate subjects. Because of the high quality of the manuscripts, which made evaluation a difficult task, and the assumption of new duties by the judges in the present emergency, announcement of winners was made later than had been expected. The winners:

1st prize: "Endocrine in the Nervous System." One full year's scholarship to Elizabeth L. Brown, Class of 1943, New York Medical College.

2nd prize: "Hormone Factors in Personality." One-half year's scholarship to Eugene B. Brody, Class of 1944, Harvard Medical School.

3rd prize: "Role of Hormones in Pregnancy and Parturition." $100 to Roslyn Wiener, Class of 1945, University of Michigan Medical School.

The Schering Award Competition is offered annually by the Schering Corporation for the purpose of stimulating a current interest in endocrinology among undergraduate medical students. Sponsored and administered by a special committee of the Association of Internes and Medical Students, the competition is now in its third year, and it is evident from the excellent response among medical students that the Schering Award has well fulfilled its original purpose. That two of the winners in this year's competition are women attests to their ever-increasing progress in the field of medical education.

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Development of a New Marinol

Development of a new improved formula for Marinol, the cod liver oil emulsion, following two years of research, is announced by B. Thurber Guild, M.D., president of Fairchild Brothers & Foster, a subsidiary of Winthrop Chemical Company, Inc., which markets the product through drug stores for sale on doctors' prescription.

The new Marinol has been further fortified with pure vitamin D_3. The high vitamin potency of 5,000 U.S.P. units of vitamin A and 500 U.S.P. units of vitamin D, which are sufficient to meet the daily re-

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quirements as established by the U. S. Food and Drug Administration, is combined with fish-liver and vegetable oils which add caloric value to the vitamin content, according to the company's literature.

The potency is described as four times as great as in the original product, which has been marketed since 1924. The prescribed new dosgae is reduced, therefore, from a tablespoonful two or three times daily to a single teaspoonful daily.

While taste and odors are well disguised with what is described as a "pleasant flavor," the new formula is also highly homogenized.

Packages of two sizes instead of one now comprise the line. The retail ceiling price is listed at 85 cents for the newly added 6 ounce size and $1.50 for the original 12 ounce size. A changed package of sea green differentiates the improved formula.

More Penicillin for Army

Work has begun on a five-story and basement reinforced concrete and brick factory and laboratory building, 182′–6″ x 82′–6″, for the Lederle Laboratories, Inc., at Pearl River, N. Y., according to plans prepared by the Chemical Construction Company. The Chemical Construction Company and the Lederle Laboratories are wholly owned subsidiaries of the American Cyanamid Company, one of the largest chemical and allied industry manufacturing concerns in America.

The general contract has been placed with the Turner Construction Company. The job has high priorities from the War Production Board, and extreme speed is required in order to meet the Army's needs for Penicillin, the remarkable new drug which the armed forces need in large quantities.

Clinical Curare: Intocostrin

Since time immemorial South American Indians have smeared curare on the tips of blow-gun darts to paralyze game in hunting. The drug is prepared by native witch doctors as an infusion of the bark and stems of certain plants, particularly from a liana or vine, *Chondrodendron tomentosum.*

Having access to the largest quantity of useful curare ever gathered, the research laboratories of E. R. Squibb & Sons have developed methods for the preparation of a highly uniform, physiologically standardized, highly stable and sterile aqueous extract. This preparation is known as Intocostrin. Each cubic centimeter is adjusted by comparative tests on healthy rabbits to conform to the equivalent of 20 mg. per cc. of a standard drug, the important ingredient of which has been isolated in crystalline form and identified as d-tubocurarine.

Intocostrin, given intravenously or intramuscularly, exhibits the typical action of pure curare, that is, interruption of the nerve impulse at the neuromuscular junction with resulting paresis or relaxation of voluntary muscle. The drug acts within a minute or two after injection; the effect lasts about fifteen to thirty minutes, disappearing rapidly as the drug is eliminated. Intocostrin has little effect on the circulation and none on the sensory nerves. It is inactive by mouth.

Whatever may be the outcome of other potential applications, Intocostrin provides one of the most important single advances in the shock therapy of mental disease, a new means for helping many congenitally disabled children in their endeavor to attain normal muscular function, and a new tool in the diagnosis of myasthenia gravis. It has shown itself safe when given in proper dosage, properly administered with full appreciation of its physiologic characteristics.

Administration of Larger Doses of Riboflavin Made Possible

A new preparation making possible administration of larger doses of riboflavin (vitamin B_2 in soluble form) by injection than was hitherto possible has been developed in the laboratories of the Winthrop Chemical Company, Inc., and has now been placed on the market.

Known as Betasynplex "Niphanoid," the preparation is described as "a highly concentrated mixture of the five factors of the vitamin B complex which have been synthesized." It is being supplied in ampuls in a stable, rapidly soluble form. Each ampul contains a full therapeutic dose of the three most important vitamins, thiamine hydrochloride, riboflavin and niacin amide, as well as a significant amount of vitamin B_6 and calcium panothenate. Boxes of three and ten ampuls are available.

★ The decline in the death rate since Christmas seals were first sold in Wisconsin in 1908 represents a saving of approximately 40,000 lives. *Crusader,* WATA

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THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

A Text-Book of Pathology. An Introduction to Medicine. By William Boyd, M. D., LL. D., M. R. C. P., Ed., F. R. C. P., Lond., Dipl., Psych., F. R. S. C., professor of pathology and bacteriology in the University of Toronto, Toronto; formerly professor of pathology in the University of Manitoba. Ed. 4, thoroughly revised. Cloth. Price, $10. Pp. 1008, with 490 engravings and 29 colored plates. Philadelphia: Lea and Febiger, 1943.

Combining as it does clinical considerations, pathogenesis, and a readable introduction to pathology, Boyd's "Text-Book of Pathology" has earned for itself a place as a standard textbook for both medical students and practitioners.

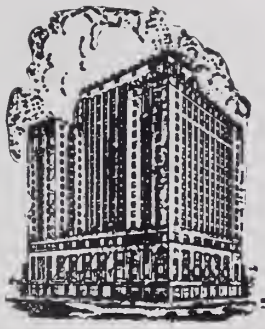
The new revised edition has been rewritten and condensed. Material on immunity and hypersensitivity has been deleted. Additions have been made, including material on the relation of vitamin K and heparin to thrombosis, virus pneumonia, the relation of the kidney to hypertension, Boeck's sarcoid, the Rh factor in erythroblastosis foetalis, equine encephalomyelitis, and lesions of the intervertebral disc, as well as other subjects. New illustrations have been added, though they contribute very little to the improvement of the book.

Dr. Boyd presents the material very well and gives both sides of controversial subjects when it is justified. His text is a worthwhile contribution to medical literature. C. J. T.

Convulsive Seizures. How to Deal with Them. By Tracy J. Putnam, M. D., professor of neurology and neurosurgery at the College of Physicians and Surgeons, Columbia University. and a director of the Neurological Institute of New York. Cloth. Price, $2. Pp. 168, with 12 illustrations. Philadelphia: J. B. Lippincott Company, 1943.

This small volume is an outline of the practical problems encountered in the management of the epileptic patient. It contains many points of interest to the physician who is called upon to care for a patient who has repeated convulsive seizures; but, since it is primarily addressed to laymen, it does not deal with details of diagnostic or therapeutic methods.

If one agrees that the intelligent and inquisitive "epileptic" patient and his family should be given a book to read about his disease, this book may be recommended with confidence. It is written in a clear and lucid style, and the facts are accurately stated. The author himself cautions against the dangers inherent in a patient's reading about his disease. Since any manual written for the patient



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must consider the disease in general, rather than the individual, it may create more problems than it solves. Many of these problems may much better be left for individual discussion between the physician and his patient.

The last chapter, entitled "For Lawyers and Legislators Only" is unique, for nowhere else in the literature has there been such a clear presentation, with references, to the legal chaos which surrounds this disorder. T. C. E.

The March of Medicine. The New York Academy of Medicine Lectures to the Laity, No. 7. Cloth. Price, $2.50. Pp. 217, illustrated. New York: Columbia University Press, March, 1943.

This book is composed of six general lectures by as many speakers on the subjects of tuberculosis, the brain and the mind, the Freudian epoch, genius, giftedness and growth, the history of the B-vitamins, and the newer knowledge of nutrition. The lectures are informative, very interesting, and written in a simple, very readable style. R. C. H.

Military Medical Manuals. Manual of Dermatology. Issued under the auspices of the committee on medicine of the division of medical sciences of the National Research Council. By Donald M. Pillsbury, M. D., consultant in dermatology to the committee on medicine; Marion B. Sulzberger, M. D., major, Medical Corps, U. S. Army. Cloth. Price, $2. Pp. 421, illustrated. Philadelphia: W. B. Saunders Company, 1942.

This is one of a series of manuals prepared for the medical departments of the Army and Navy. Therefore, the emphasis has been placed on the common skin diseases of the age-sex group found there. Nevertheless, the book is of considerable value to the general practitioner, for the management of cutaneous diseases has been set forth briefly and simply. The format and illustrations are excellent. The index is quite complete.

There are several departures from the standard textbook presentation which are worthy of note. Chapter III illustrates schematically the diagnosis based on distribution. Chapter IV deals with the diagnosis of eruptions of commonly involved sites and includes eighty full-page photographs. Chapter V dealing with the local treatment is extremely practical. The treatment is divided into simplified, or ambulatory, type and hospital management. Throughout the book the specific treatment for each condition is referred to by a number which is listed in the formulary of the appendix. This saves considerable repetition.

In all, there are eighteen chapters. The ones on pyodermia, fungus infections, and penile lesions are especially noteworthy. G. A. C.

Obstetrical Practice. By Alfred C. Beck, M. D., professor of obstetrics and gynecology, Long Island College of Medicine; obstetrician and gynecologist-in-chief, Long Island College Hospital, Brooklyn. Ed. 3. Cloth. Price, $7. Pp. 938, with 1100 illustrations. Baltimore: The Williams and Wilkins Company, 1942.

This new edition of a book that has already made a permanent place for itself in obstetric education

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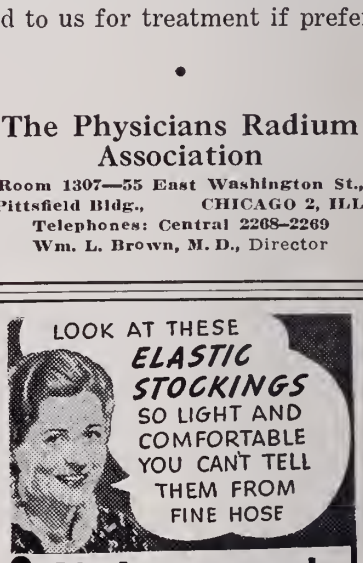

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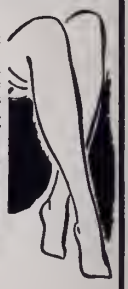

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has been thoroughly and completely revised and brought up to date in accord with present day knowledge. This book has three features that are peculiarly noteworthy. The medical and surgical complications of pregnancy receive the consideration which they deserve. Female reproduction is not presented as a subject limited to the generative tract but as involving the entire organism and accompanied by all the hazards that befall women in this age group. Operative obstetrics is presented in seven detailed chapters and with much more completeness than is usually found in most textbooks. As long as the large majority of women are delivered by general practitioners, it will be necessary to teach operative obstetrics to the undergraduate. This book meets this need in a most acceptable manner.

The illustrations are particularly noteworthy. Of the eleven hundred, most are simple line drawings made by the author. Leaving much to be desired from the standpoint of artistic beauty, they are made with obstetric accuracy and are especially valuable as explanations for the undergraduate student. J. W. H.

Nutrition and Diet in Health and Disease. By James S. McLester, M. D., professor of medicine, University of Alabama, Birmingham, Alabama. Ed. 4, thoroughly revised. Cloth. Price, $8. Pp. 849. Philadelphia: W. B. Saunders Company, 1943.

McLester's excellent book, "Nutrition and Diet in Health and Disease," has been thoroughly revised and brought up to date. The chapter on vitamins has been revised and the discussion of mineral elements enlarged. The requirements of the nutritive essentials has been rewritten to conform with the standards of the "yardstick of nutrition." Part II, Nutrition in Disease, has been revised, and discussions on diet in old age and nutrition in industry have been included.

The book presents to the professional reader a very complete and accurate discussion of normal nutrition and its therapeutic variations. An excellent bibliography is included at the end of each chapter. McLester's "Nutrition and Diet in Health and Disease" would be a fine choice for the professional reader who wishes one book to cover the subject of normal nutrition and diet in disease. R. D.

Essentials of Gynecology. By Willard R. Cooke, M. D., professor of obstetrics and gynecology and head of the department at the University of Texas School of Medicine. Cloth. Price, $6.50. Pp. 475, with 97 illustrations. Philadelphia: J. B. Lippincott Company, January, 1943.

This new textbook is just what its title indicates: compact, concise, clearly written, well illustrated, and beautifully printed. The author, who has had long experience in the teaching of undergraduate medical students, amply reflects this experience in the content of his book. The anatomy and pathology of the female generative tract are well presented, but some may question the brevity of presentation accorded to physiology, especially endocrinology and embryology. The author has devoted little space to

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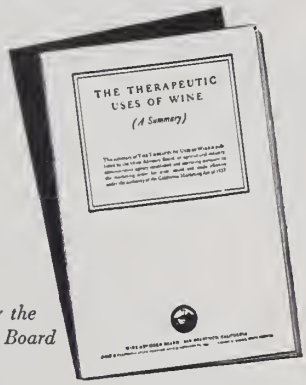

Published by the Wine Advisory Board

An entire generation of physicians lost touch with the medical lore of wine in the United States following the first World War. Actually, however, few other substances have been as widely recommended. This monograph, which summarizes the pertinent scientific literature in the interest that fact be separated from folklore by the application of impartial analysis, will prove of interest and value to specialists in many fields, and to the general practitioner as well.

A section on wine as a food is included. The actions of wine on the gastro-intestinal system, the cardio-vascular system, the genito-urinary system, the nervous system and the muscles, and the respiratory system are discussed. The uses of wine in diabetes mellitus, in acute infectious diseases and in treatment of the aged and convalescent are dealt with. There is a section on the value of wine as a vehicle for medication. Also an important section on the contraindications to the use of wine. Those who wish to pursue the subject further will find an extensive bibliography.

This review results from a study supported by the Wine Advisory Board, an agricultural industry administrative agency established under the California Marketing Act, and has been sponsored by the Society of Medical Friends of Wine.

Members of the medical profession are invited to write for this monograph. Requests should be made to the Wine Advisory Board, 85 Second Street, San Francisco.

the technic of operative gynecology, which, to the reviewer, seems entirely proper in a text intended primarily for the undergraduate.

Chapter 4, entitled "The Patient Herself—Mode of Life and Psychologic Factors," strikes a peculiarly appealing chord in the reaction of every gynecologist. It is veritably a mine of useful advice to the beginner in a field that has received all too little attention in medical education. Another chapter on postoperative complications is the best presentation of the subject with which the reviewer is familiar.

This review cannot be closed without another reference to the illustrations. The author is to be congratulated on the wisdom of their choice, and the publishers have reproduced them with a degree of fidelity, clarity, and beauty all too rarely encountered in American textbooks. J. W. H.

Skin Grafting of Burns. Primary Care; Treatment; Repair. By James Barrett Brown, M. D., Lieutenant Colonel, Medical Corps, Army of the United States; senior consultant in plastic and maxillo-facial injuries and burns, E. T. O., U. S. A.; associate professor of surgery, Washington University, St. Louis, Missouri, and Frank McDowell, M. D., assistant in clinical surgery, Washington University, St. Louis, Missouri. Cloth. Price, $5. Pp. 204, with 131 illustrations. Philadelphia: J. B. Lippincott Company, 1943.

This extremely interesting book reviews the technic of the application of skin grafts and various other types of grafts. It stresses the necessity of a clean field, describes the type of graft to be used in specific individual cases, and emphasizes the use of the fixation dressing postoperatively.

A short resumé of other types of plastic procedures, such as those with pedicle flaps and readjustment plastic procedures, is also given. S. K. W.

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Mental Health in College. By Clements C. Fry, M. D., lecturer in psychiatry and mental hygiene and psychiatrist to the Department of University Health, Yale University, with the collaboration of Edna G. Rostow, research assistant in psychiatry and mental hygiene division of college psychiatry and mental hygiene, Yale University. Cloth. Price, $2. Pp. 353. New York: The Commonwealth Fund, 1942.

For anyone interested in the problems involved in the practice of psychiatry among college students, this book is to be recommended. It says little that is new though much that every university psychiatrist can heartily subscribe to. The authors discuss in summary a variety of cases illustrating major types of difficulties encountered. Considerable vagueness as to therapeutic measures seems to be present, but this may have been done with a purpose. Undoubtedly, in many cases the authors resorted to deeper and more detailed therapy than they have recorded in order to have obtained their good clinical results. A. C. W.

Diseases of the Skin. By Frank Crozer Knowles, M. D., professor of dermatology; Edward F. Corson, M. D., clinical professor of dermatology; and Henry B. Decker, M. D., assitant professor of dermatology, Jefferson Medical College, Philadelphia. Ed. 4, thoroughly revised. Octavo, pp. 621, illustrated with 272 engravings. Cloth. Price, $7. Philadelphia: Lea and Febiger, 1942.

This is the fourth and revised edition of this textbook by Knowles. Corson and Decker now appear as coauthors.

The usual textbook form has been retained. The conventional fourteen classes of diseases are presented. New diseases are discussed under additional headings.

Some of the old photographs have been replaced by new ones. The use of sulfonamides and vitamins in dermatology has been adequately covered. Illustrations of histopathology are notably lacking.

Unfortunately, the chapter on tropical diseases, at a time when they are becoming more and more important, is not very extensive.

The book is clearly written and will be of value to the general practitioner and the undergraduate student. G. A. C.

The 1942 Year Book of Obstetrics and Gynecology. Edited by J. P. Greenhill, B. S., M. D., F. A. C. S., professor of obstetrics and gynecology, Loyola University Medical School, Chicago; professor of gynecology, Cook County Graduate School of Medicine; attending gynecologist, Cook County Hospital; attending obstetrician and gynecologist, Michael Reese Hospital. Cloth. Price, $3. Pp. 672, illustrated. Chicago: Year Book Publishers, 1942.

This review of the 1942 publications in obstetrics and gynecology, done entirely by Dr. J. P. Greenhill this year, equals the standards which it has maintained in the past years. It should be in the library of all who practice obstetrics and gynecology. M. J. T.

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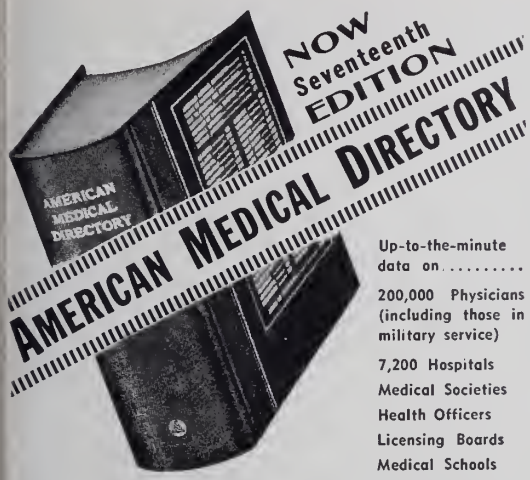

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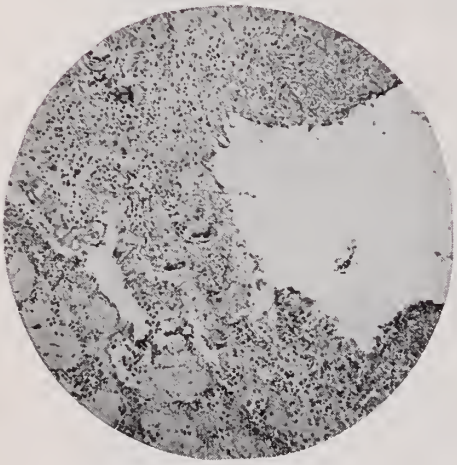

Photomicrograph showing cytological detail in acute lesion of mucosa of colon. Magnification x 650.

REFERENCES:

LYON, G. M.; FOLSOM, T. G.; PARSONS, W. J., and SPROUSE, I: West Virginia M. J. 38:19 (Jan.) 1942.

LYON, G. M.: U. S. Nav. M. Bull. 40:601 (July) 1942.

BREWER, A. E.: Brit. M. J. 1:36 (Jan. 9) 1943.

FAIRLY, N. H., and BOYD, J. S. K.: Brit. M. J. 2:673 (Dec. 5) 1942. (Proc., Royal Society of Tropical Medicine and Hygiene, Nov. 4, 1942).

BULMER, E., and PRIEST, W. M.: J. Roy. Army M. Corps 79:277 (Dec.) 1942.

RANTZ, L. A., and KIRBY, W. M. M.: J. A. M. A. 118:1268 (Apr. 11) 1942.

OPPER, L., and HALE, V.: J. A. M. A. 119:1489 (August 29) 1942.

KUHNS, D. M.: South. M. J. 36:393 (June) 1943.

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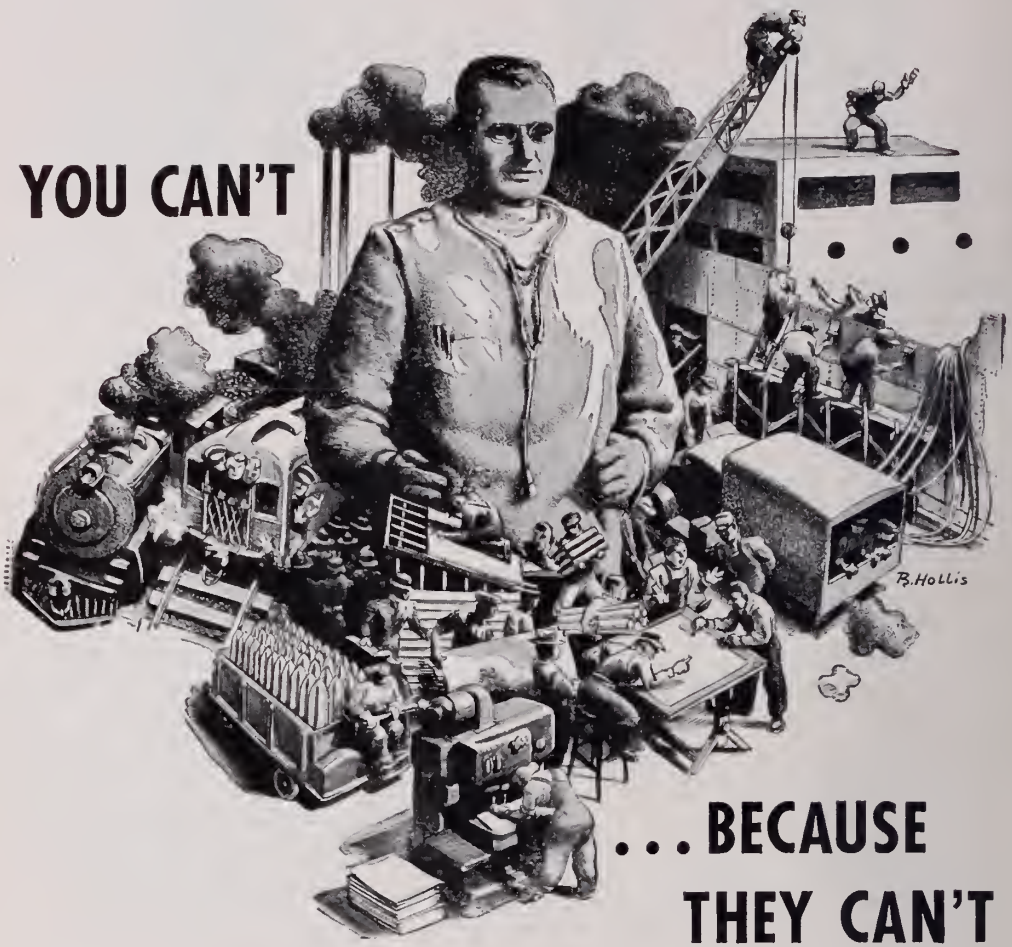

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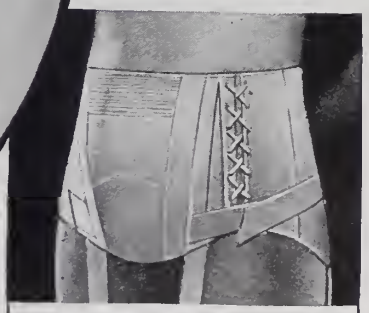

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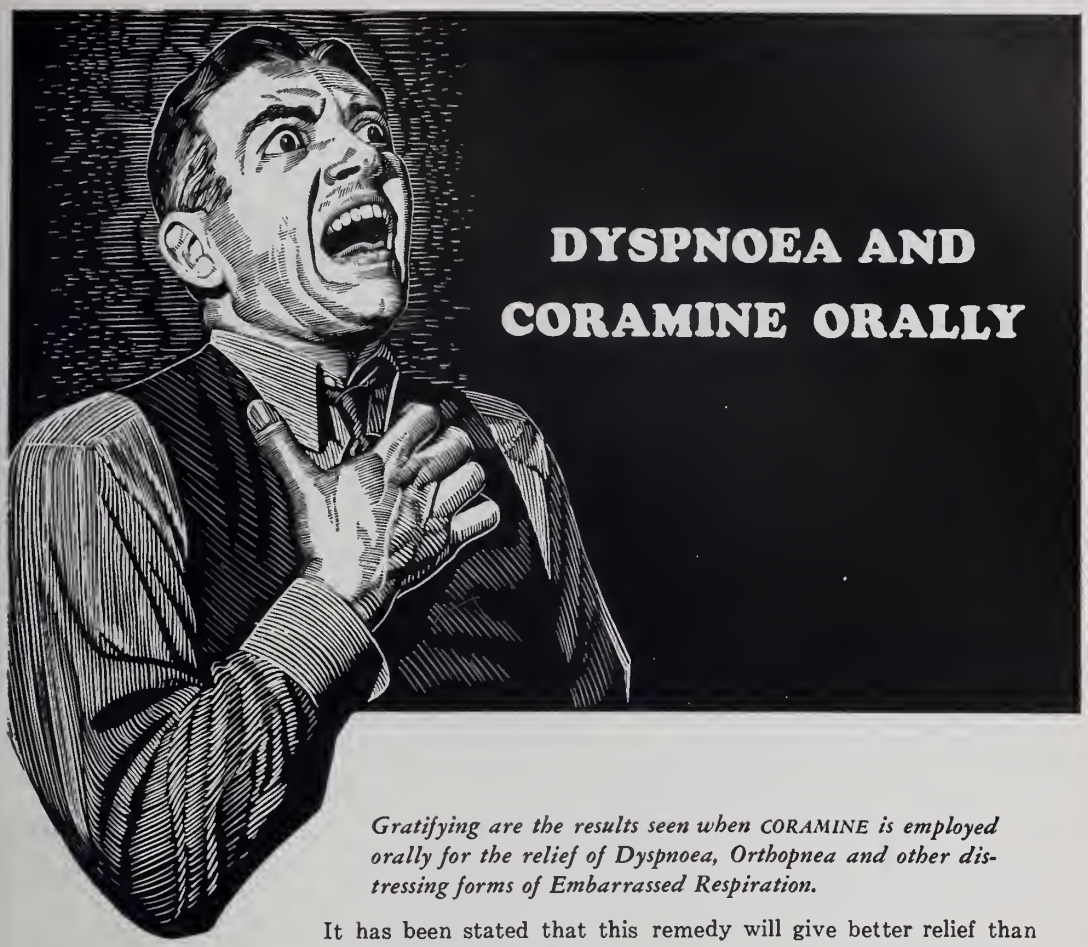

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[1]Lankford, J. S., "Coramine," Clinical Medicine & Surgery, 37, 670, 1930.

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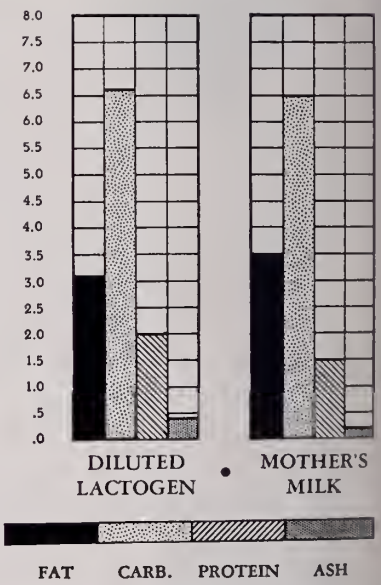

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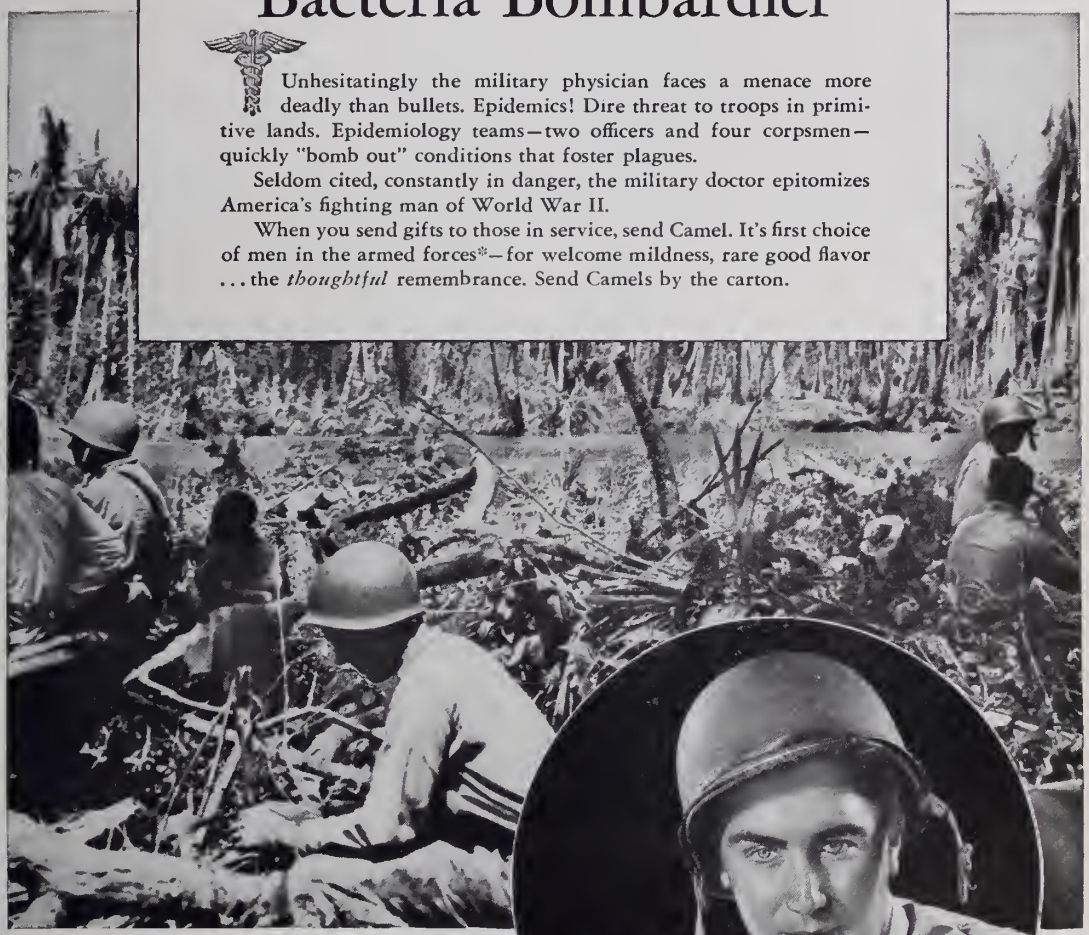

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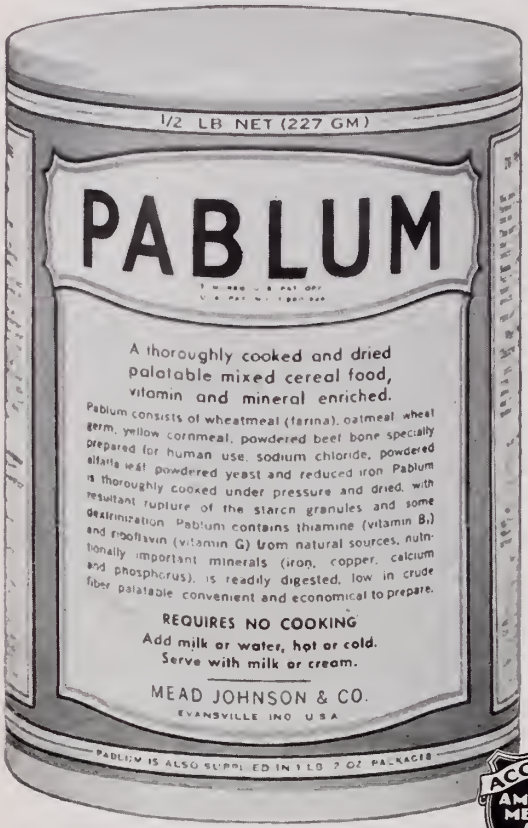

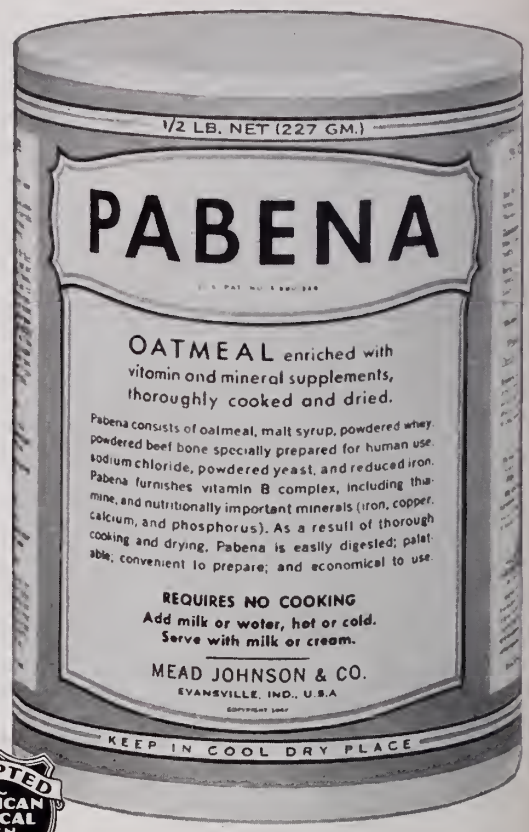

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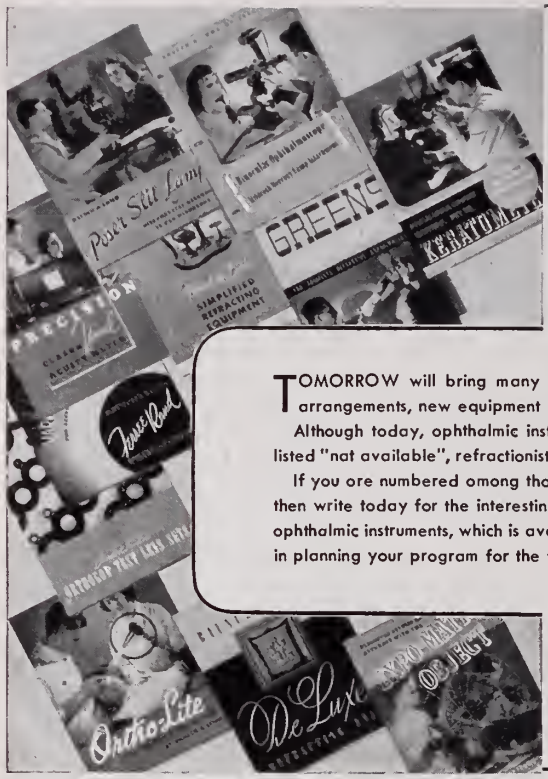

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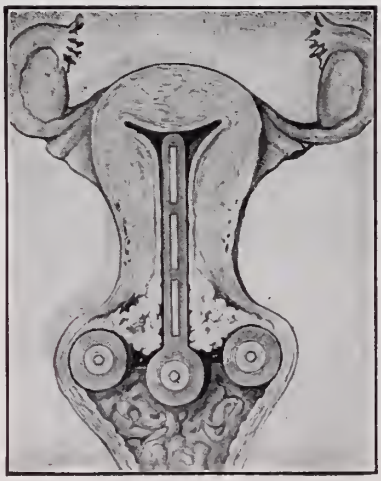

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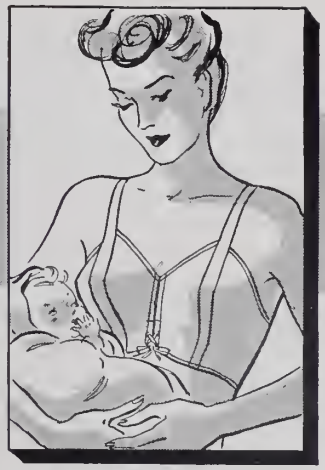
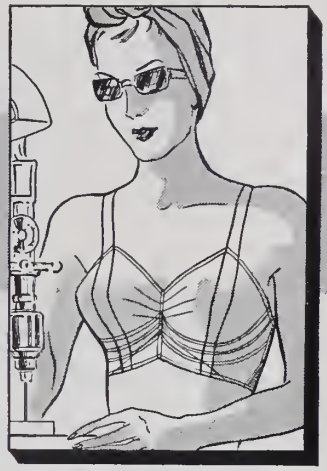


Nursing Mother



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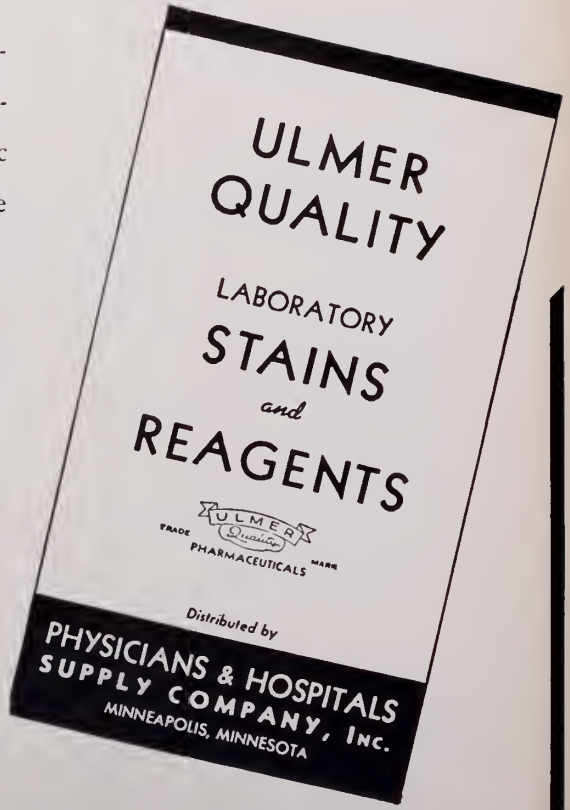

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ESTABLISHED 1898

THE WISCONSIN MEDICAL JOURNAL

VOLUME 42, NO. 11 Copyright, 1943, by The State Medical Society of Wisconsin NOVEMBER, 1943

Administrative and Professional Problems of Medical Practice in the Hospital*

By ALPHONSE M. SCHWITALLA, S. J.
St. Louis

FATHER ALPHONSE M. SCHWITALLA

Dean, St. Louis University School of Medicine, St. Louis, and President, Catholic Hospital Association of the United States and Canada.

THE title of my comments suggests a problem to which the House of Delegates of the American Medical Association and its various committees have devoted a great deal of time and attention. Even after all such discussion, it is evident that a final word has not as yet been spoken on the subject. Such comments as I might here make, needless to say, should be taken as personal views and do not constitute an official attitude of any association or group which I might be thought to represent.

At the outset, it must be recognized that we are here dealing with a controversy. Fortunately, however, the controversy is one in which difference of opinion arises not from any unwillingness on either side to recognize the rights of the other side but from a lack of clearness in administrative procedure which makes it most difficult to achieve a procedure which will, first, safeguard what is best for the patient; second, safeguard the interests of the physician; and third, the interests of the hospital; for it must be understood that those who have taken part in the numerous conferences that have taken place have been actuated by a sincere desire not of promoting their own self interests but of achieving a procedure which will really protect the patient. There is room, therefore, for no recriminations by physicians of the hospital or by hospitals of their staff members. The situation can only mean that the proper formula which should form the basis of agreement and compromise has not as yet been found. I should be foolhardy if I promised this audience anything new in an area of hospital and medical interest in which some of the best minds in both fields have attempted to find a solution for a problem of long standing. I can do little more than review in essence, and very briefly, what other students of the problem have already said much more aptly than I can hope to say it.

I. THE PROBLEM

The problem is essentially this. In the hospital, there are one or more medical practitioners who for one reason or another in the past have not practiced medicine on an individual basis but have practiced their profession as salaried appointees and, hence, as agents of the hospital. By supposition, there can be no doubt about the fact that these physicians are engaged in the practice of medicine. Since, in that practice, their status as employees and, hence, as agents of the

* Presented before the One Hundred Second Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1943.

hospital, must be recognized, the hospital is thus engaged in the practice of medicine, a situation which contravenes not only the legal prescriptions of many of our states, but, what is even more important, it contravenes and violates a fundamental ethical requirement in the practice of medicine. As all know, these physicians of whom we are here speaking are those who give certain generalized services in the hospital, such as the pathologist, the laboratory physician, the radiologist, sometimes the physiotherapist and the anesthetist. Among these, the radiologists, for many reasons, have been confronted by this problem in a peculiarly acute form not only because of the particular nature of their specialty but also because financial relationships are involved which may easily lead, and have de facto often led, to the commercial exploitation of the radiologist by the hospital and to allegedly justifiable dissatisfaction with the hospital on the part of the radiologist.

The situation has become accentuated by the entry into the field of hospital administration of the group hospitalization plans, many of which are said to be purchasing medical care from their cooperating hospitals and are thus said to be liable to the charge of unethical practice. The hospitals, on the other hand, contend that under the present pattern of hospital administration, particularly with reference to staff organizational plans, any other arrangements than those now in effect would adversely affect the patient. Since, therefore, the primary objective of both the medical profession and of the hospital is the safeguarding of the patient's welfare, either we should be forced to sacrifice that welfare or we are forced by logical necessity to devise a procedure different from the one now in more common operation. Thus far, the dilemma stands unchallenged or, to speak more exactly, not unchallenged but unresolved. From the hospital's point of view, the problem has been intensified by the recently developed increased shortage of radiologists which has made it necessary that one radiologist, in some localities, serve not one but several institutions from each of which he derives income often to an extent, so it is said, out of all proportion either to the amount of time which the radiologist devotes to any one of the institutions, or to the remuneration derived by other physicians from their hospital practice.

II. THE CASE FOR THE PHYSICIAN

It cannot be denied that the functions of the hospital pathologist, the laboratory physician, the physician anesthetist, the physiotherapist, and the radiologist belong essentially to the area of medical practice. As such, these medical specialists are subject to the same ethical requirements as are the internist or the surgeon, the obstetrician or the ophthalmologist. Their work is essentially to be regarded as a professional service to the individual patient; their work should be carried out strictly in the spirit of the personal relationship between physician and patient; there should be interposed in that relationship no third party. The service should not rest upon considerations of financial return but solely, according to the very first principle of ethical practice, upon the need of the patient for medical services. If any of these physicians enter into contractual relationships with an organization or institution, they, like all other physicians, the general practitioner as well as the specialist, must safeguard the ethical character of that contract. These five groups of specialists giving general hospital care must be just as careful and conscientious in their avoidance of fee-splitting as the surgeon and the surgical specialist is required to be. All of this and all that is implied in it and all that might be said in amplification is all theoretically sound and basically true.

General Service Physicians Remote From Their Patients

In practice, however, we find the situation considerably different from the ideally and theoretically correct situation. The pathologist and the laboratory physician and the radiologist and the physician anesthetist and the physiotherapist are often more or less remote from their patients. As a general rule perhaps, or surely in general practice, the patient not only does not see these physicians but probably has never been made actually aware of their assistance or of their essential

participation in hospital service. If, on rare occasions, they should find the signature of one of these physicians on a sheet included in the patient's history, the patient would probably find himself completely ignorant of the services rendered by these physicians. There is interposed between the patient and these general service physicians a vast multiplicity of physical things such as the elaborate paraphernalia of the laboratory, the mysterious machinery of the radiographic room, the complex gas machines of the anesthetist and the museum-like display of the physiotherapy department. A casual observer who does not understand the intricacies of modern medical practice would say that these five general service physicians are occupied with things rather than with human beings, with machinery and laboratory contraptions rather than with a suffering patient. The concept is hard to convey even to students of medicine that the pathologist or the laboratory worker is concerned even in the least with the patient, for it seems a far cry to interpret interest in a microscopic section of tissue or a test tube full of blood or urine or of mother's milk as interest in the patient, in his or her bed suffering from any one of the thousands of derangements listed in the standard nomenclature of diseases. Similarly, it seems a far cry from the tubercular lung to the radiographic picture and from the arthritic joint to the diathermic lamp.

Responsibility is the Important Consideration

It is a far cry but only for the person who does not understand the meaning of medical responsibility. Medical practice is not based necessarily and always and under all circumstances on immediate and first hand contact with the patient. What is important in determining what is and what is not medical practice is responsibility. There can be no doubt about the nature or the extent of the responsibility of the pathologist or the laboratory physician or the anesthetist or the physiotherapist or the radiologist. The lives, the welfare, the safety of patients depend upon the decisions which these men render, and the responsibility for these decisions implies competence, sincerity, a love of truth, an unselfishness just as acute in its respective area as is the responsibility of the internist and the surgeon. There can be no doubt about the validity of the principle enunciated in the resolutions of the House of Delegates and of several reference committees of the House in the American Medical Association when they assert that the practice of the pathologist, of the radiologist, and of the others whom we have so often mentioned in these remarks is essentially the practice of medicine.

The case for the doctor can be strengthened still further. If all our reasoning thus far is accepted, it would follow that the pathologist and the radiologist and the others are entitled to their respective honoraria on the same basis as are other physicians who are engaged in private practice. Here precisely other acute problems make their influence felt. If these general service physicians had from the beginning regarded themselves as consultants in the same way as the gynecologist or the otolaryngologist is a consultant when he is called in to a consultation by the internist who is attempting to make a diagnosis, many a problem in the present day practice of medicine might have been forestalled. As a matter of fact, however, for one reason or another, all of them no doubt amply warrantable at the time, radiologists and pathologists and others engaged themselves to hospitals and, probably without fully realizing the implications of their position, placed themselves at the disposal of the hospitals on a salary basis thus becoming agents of the hospitals and exposing the hospitals to the accusations which are today hurled at them, namely, that they are corporations which are practicing medicine. No doubt there was in all of this no intention on the part of the physician to violate fundamental ethical principles; on the other hand, it is more than likely that the development of the relationships between the pathologist and the radiologist, on the one hand, and the hospital, on the other, as they exist today, are explained more or less in the way in which I have indicated. The reasons for such a development are not far to seek. The necessity of the elaborate equipment essential in radiology, for example, or in the laboratory, the further necessity of having all of this equipment close at hand in the hos-

pital, the continuous and daily use of this equipment, the impracticability of ownership of all of this equipment by the physician should his practice be scattered over more than one institution, these and a hundred related problems explain the present situation.

Relation of the General Service Physicians to the Hospital Staff

More subtle still is another situation to which just a brief word must be devoted. In many an institution throughout the land, the pathologist or the radiologist, and the same should be said in a measure for the other physicians whom we are considering, do not consider themselves as intimately associated with the staff. I emphasize the fact that this is not a universal condition. It is general enough, however, to afford an explanation of conditions as they exist in some institutions. The pathologist is often a critic of the staff as he is bound to be with reference to the staff's medical practice. The radiologist is frequently looked upon as a mere radiologic diagnostician, scarcely if ever seeing the patient prior to the patient's entry into the radiologic laboratory and then not for the purpose of a general clinical study but for the specific purpose of a radiologic study. The anesthetist in some institutions rarely, if ever, knows the patient prior to the patient's admission to the operating room. Sometimes he takes no responsibility for the preanesthetic procedures, and unless he is specially interested in particular surgical problems, he is not too concerned with the general clinical condition of the patient. What has been said of the pathologist can be said almost in the same terms of the laboratory physician, and the physiotherapist is apt to use his science and skill without having participated in a thorough clinical review of the patient's illness. It is fully recognized that these conditions if and where they exist are explicable by a multiplicity of reasons, all of them valid. The point I am making here is not a criticism of the situation but rather an explanation of the somewhat aloof position which the physicians whom we are here discussing are likely to occupy in the hospital staff.

Financial Arrangements

Finally, in discussing the case for the physician, we may glance at the financial arrangements. The radiologist has sometimes found it most convenient to accept a salary rather than to send his own statement to the patients whom he examines or treats. The same might be said of the other medical officers about whom this question arises. Here again it would seem that feasibility, facility in collection, a general desire to save time and energy rather than any desire to engage in practices that might suggest fee splitting between the physician and the hospital, have been the determining factors. And yet, it is equally true that from these arrangements many of the abuses of which we complain today have arisen.

The case for the physician, that is, for the pathologist and the radiologist and the laboratory physician and the physician anesthetist and the physiotherapist is a strong one. We cannot but accept the emphatic pronouncements of the House of Delegates of the American Medical Association with reference, for example, to radiology, "Radiology is a department of medicine and the practice of radiology is the practice of medicine." The same principle merits our complete acceptance as applied to the other specialties which we have here so frequently mentioned.

III. THE CASE FOR THE HOSPITAL

The case for the hospital, I am entirely willing to admit, is far from being equally convincing. It is my frank opinion that the hospitals are today more than eager to modify their policies and practices to conform with the principles so unmistakably declared by the American Medical Association, so consonant with the broad principles of ethical medical practice, and so sound as the basis of administrative procedure. No one who knows the broad facts in the national picture can call into question the statement that evidence is accumulating "of continued encroachment of hospitals into the practice of medicine" which they do by offering "certain medical services on a service basis as a part of hospital care." No one can question the soundness of the resolution of the House

of Delegates "that hospital corporations should not be permitted to engage in the practice of medicine through the medium of employed physicians or to enter into contract with any individual group, or agency, whereby the hospital agrees to furnish any medical services." Again, personally, I cannot but subscribe with emphasis to the principle that "all fees for medical services rendered in hospitals should be collected by or on account of the physician rendering such service, and all physicians concerned in the care of a patient should give or send directly to the patient, or other responsible party, a statement showing charges for professional services rendered." The hospitals in which staff relationships are on a safe and sound basis will extend that basis to include all its medical staff members and not merely those who are engaged directly and chiefly with bedside care. Where, therefore, is the difficulty?

Violation of Fundamental Medical Ethics

Most immediately, it seems to me, and influential in the present situation is the relative universality of what in the light of our present discussion we cannot but regard as violations of fundamental medical ethics. In reviewing the types of radiologic hospital contracts, a recent issue of *The Journal of the American Medical Association* tells us that "37 per cent of all radiologists are employed on a salary basis" inclusive of the radiologists in government hospitals and in other full-time positions; that "9 per cent lease the departments on fixed rental"; that "54 per cent share gross receipts or net receipts with the hospital," but that "of this 54 per cent . . . about half (27 per cent) are under legal relationships which make the radiologist a tenant, and about half (27 per cent) an employee of the hospitals." On the basis of these statistics, the contracts between radiologists and the hospitals are of such a character that no fewer than 64 per cent of the radiologists are agents or employees of the hospital, that is, 37 per cent who are on a salary basis and 27 per cent who are on a shared receipt basis. As long as this situation continues, the problem which confronts the hospitals is obviously that the contracts must be so revised as to make the radiologist an independent and fully responsible medical practitioner. Here is one of the great problems of the hospital.

Independent Statements

The procedures implied in this revision of contracts is probably not as simple as it may seem. The problem must, nevertheless, be faced. It has been pointed out by hospital administrators that fundamentally important changes will ensue if the patient receives independent statements from the five specialists whose practice we are here evaluating. Patients, to be sure, today who are able to carry the responsibility for their health care are accustomed to receiving statements from consultants. They understand fully and are generally sympathetic with consultation fees. If this matter is to be put on a sound basis, the patient must expect separate statements from the laboratory physician, from the pathologist, the radiologist, the physiotherapist and the anesthetist. Hospital administrators contend that under such circumstances the curtailment of special services will be inevitable, just at a time when medicine is able to place at the disposal of the patient a greater number of diagnostic and therapeutic laboratory procedures than at any other time in medical history; just at a time when scientific medicine has reached a development which enables the physician to use laboratory findings with the utmost effectiveness in his interpretation of the patient; just at such a time, so hospital administrators have said, we are making it more difficult for the patient to avail himself of the rich results of scientific research by interposing an increased number of financial hazards between the patient and the availability of scientific results. It must be admitted that there is much value in the argument. The hospital is entitled to some remuneration for the use of laboratory equipment whether it be in the biochemical laboratory, the bacteriologic, the radiologic, or the physiotherapy laboratory. It is entitled to some return on the space occupied by these laboratories, and it

is even more entitled to a return for the salaries and, in some cases, for the maintenance of the technical personnel in these various fields. It is difficult to conceive, therefore, that the hospital will relinquish a right to a return from the patient for some of these expenditures. It is hard, therefore, to conceive how the hospital will give up some form of a charge for the laboratory fee either separate from the room rental or included in an overall blanket per diem payment for hospital facilities. Probably this multiplication of statements which has been suggested will have the unquestioned effect of reducing requisitions for laboratory studies and for diagnostic and therapeutic procedures.

Where Does Medical Responsibility End?

But there are other considerations both theoretical and practical in nature which, it would seem, can make an early solution of this problem extremely difficult. I refer here to the very great difficulty in knowing always where medical responsibility ends. I wish to insist that I am far from advocating a narrow definition of medical responsibility. I cannot find myself in accord with the point of view of those who would draw too fine a line between medical responsibility and a technologic procedure. Posturing of a patient in the radiologic laboratory is often regarded as the responsibility of the technician. She is taught posturing by elaborate demonstrations and explanations, and yet no one with even unlimited experience knows in how many phases of the posturing process a measure of medical responsibility, and sometimes an extremely great measure, is involved. Similarly, the physiotherapy technician has been entrusted with responsibilities which, to me, are at times appalling. Sometimes even seemingly nonsignificant procedures and massage imply, on closer analysis, a degree of medical responsibility which is far greater than the responsibility implied in the writing of many a prescription, yet too facilely altogether we regard prescription writing as medical practice and massage as the legitimate province of the technologist.

Instances of my meaning need not be multiplied before this audience. Suffice it to say that if we really could supply physicians for all the areas in which a measure of medical responsibility is exercised, many a procedure in medical practice today would have to be greatly modified and the supply of physicians would have to be greatly increased. In this very respect, there are crucial and, in some instances, critical problems which confront us just in this day when nurses, technicians, social workers, and others are invading the field of medical practice under the enormous pressures of today's needs. What answer the future will hold for this very real and practical difficulty it is today too early to tell. We need clarification of issues at a thousand points. It seems almost ridiculously undignified that the physician with his high competence and his professional devotion to the practice of medicine must defend his rights to sound medical practice against the regiments of those who have been trained none too well in theory and scarcely better in skills in some limited field of care for the sick human being. But such are the times in which we are living.

The Hospital's Financial Problems

The hospital is concerned also with financial returns. It has been urged by sincere defenders of sound medical practice that the hospitals had exploited their radiologic departments and that the hospitals are using their profits from the conduct of the radiologic departments for covering their losses in the conduct of other departments. This charge is not made as frequently with reference to the laboratory or the physiotherapy department or the department of anesthesia. It seems that the radiologic department must bear the chief brunt of this accusation. There may be behind such thinking some measure of misunderstanding regarding financial administration. It would complicate administration beyond measure if every department of the hospital were or had to be a self-liquidating department. In fact, the modern hospital is a reality and renders such remarkable service to a large extent because the returns from one department can be used to defray the expenses of another. As a mat-

ter of fact, some hospital departments taken by themselves and not as a part of the whole organization are not able to earn an independent departmental income. It is abundantly clear, therefore, that if all departments of the hospital were permitted to charge for their services only what is actually expended in each department, the hospital, as we understand it today, would cease to exist. Despite all of this, it must be admitted that radiologic charges in some hospitals are probably unwarranted. To suggest this as a general charge against radiologic departments, however, is also an unwarranted generalization. The radiologist enters into this situation as the exploited victim, the contention being that he is in some instances not adequately paid for his services when these services are measured in terms of departmental income. It is contended that that is one of the reasons why hospitals do not care to relinquish either their ownership of their physical facilities of the radiologic departments nor the salary basis for remuneration of their radiologists.

Elimination of Salary Basis of Payment

To be sure, accounting problems in this area are notoriously difficult. Whenever allocations of general charges are to be made against departments in an organization, controversies are bound to ensue, and the process of reaching agreements among all parties in interest is sometimes painful and long and, at times, entirely disappointing. Is it any wonder that hospitals which have been accustomed to deficits over long periods of years, even though temporarily they are balancing their books in black rather than in red, are fearful about multiplying their problems by facing the issue we are here discussing, even though I must again insist that in my opinion the hospitals should frankly and with complete sincerity face the necessity for a complete reorganization of many of our present day procedures? The hospitals have insisted that to effect this we need a breaking away from the salary basis of all of these physicians who are rendering general service. They point out that if the radiologist and the other physicians giving such general service desire to place their services on the basis of a personal relationship with the patient, the first step will be the elimination of the salary basis of payment. It seems difficult for hospital administrators to accept a double system of remuneration for the radiologist and for physicians similarly placed, that is, a salary and, in addition, the right to submit statements to individual patients for individual services. The simplest solution of the basic difficulty would seem to be that the radiologist agree that a salary basis for all except those who are serving on full time will be discontinued and that all clinicians who devote part of their time to a particular hospital will submit statements to individual patients, except in those instances in which the hospital is giving entirely free services to a particular patient. For those who are paying part-pay hospital rates, the honorarium of the radiologist will be adjusted. At one of the numerous conferences held on this topic, one of the consultants thought that such a basis would be acceptable to the radiologist if the hospital would agree. Representatives of the hospitals retorted that the hospitals would have little difficulty in adjusting their charges to a changed program, but they fear the radiologists would not agree since, without doubt, a statement of fees sent to individual patients by the individual radiologist would tend to reduce the demand for radiologic service, thus imperiling not only the safety of the patient but also the income of the radiologist himself, not to speak of the reduction in the income to the hospital. Unfortunately, on such a proposal or similar ones, it is difficult to secure unanimity of opinion from the radiologists themselves. The radiologists hope, therefore, that the hospitals may take the initiative in the matter and may desist from appointing radiologists, pathologists, anesthetists, physiotherapists and laboratory physicians on a salary basis. It has been suggested, furthermore, that when the radiologist cannot collect a fee from the indigent or the medically indigent, the hospital should pay an adjusted fee on the theory that it is the hospital

which is offering free or part-pay care to the indigent and the medically indigent. And so we have suggestions and counter suggestions, all, in the last analysis, reducible to this problem, since there is agreement upon the basic principle should the initiative in the application of the principle come from the radiologist or from the hospital. The hospitals contend that they would be willing to take the initiative if there were unanimity among the radiologists; the radiologists contend that they would take the initiative if they could be made to feel sure that there is unanimity among the hospitals.

IV. GROUP HOSPITALIZATION

May I say just a few words more on potential controversies of the point which we are discussing within the Blue Cross Plans? It is a well known fact that a Blue Cross Plan which merits the approval of the American Hospital Association must have the approval of the local medical society. As a matter of fact, a large number of these plans owe their initiation to the aggressiveness and planning of the local medical society. For this reason, it is assumed that the program of approved Blue Cross Plans is supervised in many instances by representatives of the local medical society and that these representatives share in a measure in the responsibility for the operation of the plan. Yet, we are told, that of the seventy-seven Blue Cross Plans approved by the American Hospital Association, half of them guarantee medical service to their subscribers. The attitude taken by the Blue Cross Plans in general is that in the operation of their respective plans they will not alter the existing admission or administrative policies of their participating hospitals. In those hospitals, therefore, in which radiologic service is included in the per diem rate, the Blue Cross Plans accept such inclusion in announcing the benefits to the subscriber for which they give remuneration to the hospital. In those hospitals, however, in which radiologic service is treated as an extra charge by the hospital, the radiologic service is subject to special remuneration by the Blue Cross Plans. It is said that some of the approved Blue Cross Plans have insisted upon the inclusion of radiologic service even when in the locality or in the particular hospital such inclusion was not part of the general administrative policy. It is contended, therefore, that "group hospitalization comes in and cements a branch of medicine as a part of hospital care and guarantees to subscribers not only bed, food and nursing care but also the services of the doctor." It is contended that "inclusion of x-ray service in Hospital Service Plans . . . inevitably leads to deterioration of quality in radiological care. There is over-utilization of the radiologist's service with a lick and promise type of radiological care."

"Subscriber's Contract Should Exclude All Medical Services"

Needless to say, in these few sentences we have attempted to summarize controversial matters upon which there is considerable disagreement not only with reference to points of view but even with reference to facts. The American Medical Association is said even to this day to stand firmly by the report of its Bureau of Medical Economics made in 1937 in which ten principles of organization and administration were recommended for guidance in the establishment and direction of group hospitalization plans. The fourth principle bears upon the subject of our discussion. It reads, "The subscriber's contract should exclude all medical services—contract provisions should be limited exclusively to hospital facilities." In evaluating the merits of the two sides of the controversy, the case for the physician and the case for the hospital are acutely accentuated both in the form of organization and in the administration of the Blue Cross Plans, since it is through the operation of the Blue Cross Plans that physicians and hospitals come into another intimate touch one with the other. It is probable that the functioning of the Blue Cross Plans introduces no new factor in the controversy except perhaps that the right of the American Hospital Association to approve a Blue Cross Plan which includes a contestable form of medical service rendered under the auspices of a hospital may be questioned. The an-

swer of the Blue Cross Plans to this point is that they will accept whatever procedure the individual participating hospital will adopt under the direction and supervision of the local medical society. The hospitals again counter by insisting that they will follow the arrangements suggested by or insisted upon by the medical profession, especially by the radiologist himself.

And so perhaps the controversy reaches back into the fundamentals of the ethical practice of medicine. It is significant that the conclusion of the minutes of one of the recent conferences held upon this point, in which representatives of the trustees of the American Hospital Association and of the boards of the American, the American Protestant and the Catholic Hospital Associations participated, reads as follows: "There seems to be unanimous agreement that the physician is supreme in the hospital in all matters pertaining to medical service rendered in hospitals."

V. CONCLUSION

For me, personally, I feel that I can unqualifiedly state my position briefly as follows:

1. The principle of the exclusive autonomy of the physician in rendering medical service to a patient must remain inviolable.

2. The ethical relationships defined in the principles of ethics of the American Medical Association with reference to consultations are sound and are conceived in the best and in the most lasting interests of the patient.

3. The application of these two fundamental principles to the practice of medicine by the physicians who give a general service is beset with numerous difficulties which should, however, with sufficient good will, competence, and sincerity, be resolvable in a manner conducive to the good of the patient and in conformity with elevated ideals in medical practice.

4. Plans should be studied which will make it possible for the hospitals to work towards the elimination of the salary basis of appointment of the pathologist, the radiologist, the laboratory physician, the physiotherapist and the physician anesthetist, so that these physicians may be in reality and not merely in name free professional and independently responsible agents and not agents of the institution in which they are carrying on their work.

5. A basis or a number of bases should be devised according to which a fair return on its investment and on its operating expenditures in the conduct of the various medical general service departments should be returned to the institution.

6. If these principles are reduced to a practical program, the controversies with reference to these questions which have centered in the Blue Cross Plans can and will be successfully adjusted provided that the Blue Cross Plans adhere firmly to the principle which they have adopted of guarenteeing to the participating hospitals continuing freedom in the formulation and execution of their administrative policies.

KODACHROME SLIDES—SYPHILIS

The Wisconsin State Board of Health has for loan a set of 94 Kodachrome slides prepared at the U. S. P. H. S. Clinic, Hot Springs, Arkansas, showing various lesions of syphilis. Any physician desiring to use this set as a basis for a scientific program can borrow it by addressing the Wisconsin State Board of Health, Madison, Wisconsin. A 2 x 2 inch slide projector and a screen will be required for such showings.

Professional Accounting*

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AS A PART of our present daily life, we have all become accustomed to the expression "Let us look at the record." We hear it from the radio loudspeaker and read it in newspapers and magazines. We are frequently forced to comply actively in order to keep up with the many governmental and other questions and requests.

Hospital accounting is nothing more than looking at the record. But, and that is an important word, we can get out of our records only what we put into them.

The simple cash record of receipts and disbursements with a daily, weekly, monthly, or annual balance is one way of keeping a set of books, and so is the enumeration of the daily variation in the hospital census. At the other extreme, we find the complicated and detailed multiple account system and, likewise, the Holarith punch card system with its opportunity for elaborate and minute detailed studies. Both extremes are useful and used, but what is it we really want and look for and should try to obtain from our hospital records? How can we make our records of real value to us and to the patients we seek to serve?

Any patient's record is as good as the history taker makes it. A staff physician, head over heels in his practice and at present occupied more deeply than ever with the additional load of an emergency period, will take one sort of a history; a medical student extern in the midst of his first course in physical diagnosis will take another. The former is brief, all too brief, and colored sharply by the patient's present complaint. After all, the physician knows the patient from former contacts and cannot take the time to go into a detailed history with its many nonpertinent negatives. On the other hand, the extern's history is taken by rote with no ability to search for or correlate pertinent findings, be they negative or positive.

History Taken by Medical Student

Every medical student is taught how to take a complete detailed history, beginning with the chief complaint and going on through the present illness to the summation of complaints and pertinent historic facts and then proceeding through the physical examination to its summation of pertinent positive findings and impressions. And upon completion, the result is an excellent compendium of personal and familial as well as social and economic facts—too much of a compendium, except if it is to be used for teaching purposes, you will say. Therefore, as the physician goes on through his hospital training days to his days of practice and specialization, the shortcuts that suit his particular practice are developed; or the history may be delegated to a nurse or even a stenographic assistant, which, after all, would be perhaps an excellent idea if the assistant were a trained record librarian. That far, however, most of us have not yet been able to go.

A plea to retain a semblance of orderliness, routine, and completeness in the taking of a patient's history is not necessary, but it should be remembered that the case history is the foundation of a hospital's professional accounting system. It must be adequate, sufficiently detailed, and uncolored by previous contacts with the patient's ills or his family's background. This latter is important, especially for the specialized practitioner who thinks along one line only, be it tuberculosis or neuropsychiatry.

But the history is only the first portion of the case record, and equal care is required for it and with it all through the patient's hospitalization and up to the time the discharge note is written.

* Presented before the Section on Hospital Relations at the One Hundred Second Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1943.

Nomenclature

That brings us to the matter of nomenclature, another basic essential. It is only natural that, from various standpoints, different systems of nomenclature have developed and been used. The older hospitals recognized the need for a standard of terminology. Thus, we have the Massachusetts General Hospital and the Bellevue Hospital classification of diseases and, from another point of view, Ponton's Alphabetical Classification. More recently we have the Standard Nomenclature of Diseases and Operations, which has the approval and backing of the American Medical Association. Each has its good points, but none is particularly simple. In practice in our hospital, it is necessary to have the classification book chained for ready reference to those desks used by residents when writing up their records.

The fact remains, however, that if satisfactory records are to be maintained, it is necessary that a recognizable system of nomenclature should be in use by all departments if any value is to come out of a compilation of the records. What system is used is not of as much importance as that it is used. In its report of March 1, 1943, the Council on Medical Education and Hospitals of the American Medical Association reports 1,105 hospitals using the Standard Nomenclature, 1,079 hospitals using one of the other three systems noted above, and 616 hospitals using other nomenclatures. However, 6,345 is the total number of hospitals listed, so the combined figures of the hospitals reporting on types of nomenclature, 2,800, indicates that standardization in this respect is far from an accomplished fact.

Safekeeping of the Records

Besides an adequate history and the use of a standard form of terminology, another matter of importance consists of the methods and personnel concerned with the safekeeping and filing of the records. Financial records of a hospital are usually kept in a safe under the direction of trained accountants. We may appreciate the greater value of patients' clinical records, but either we do not or are unable to express that appreciation in a comparable method of safekeeping under the direction of trained guardians. But while the ever-increasing volume of case histories that must needs be kept in their entirety may preclude the use of fireproof steel vaults for their storage, there is no reason why the use of trained persons to handle them should not be possible.

The usefulness of the trained record librarian need not be argued here, but it has always appeared to be far easier to obtain funds for a clerical staff to look after funds than a similarly well trained staff to search out the end results of the use and application of those funds, the staff that is concerned with the professional rather than the financial accounting. Just as it takes training to develop a good auditor, so also it should require trained persons to handle these physical account books to set up the proper filing system and to see that it works properly, to check and classify the individual items of the physical accounts, and to set up the accounts so that they may be of value to the staff and the patients.

Having considered the basic essentials, let us now consider necessary objectives.

What do we want in the way of professional accounting? What use do we want to make of it, and how are we to achieve our demands and desires? Can professional accounting be developed in such a manner that it can be standardized as a yardstick for all hospitals? Will the yardstick of achievement fit all the varied types of hospitals we represent?

There is a preponderance of surgical cases in the majority of hospitals. Can the same rules be applied also to end results in the medical cases treated? We have seen an increase in the use of hospitals for obstetric cases. Here we have another type of end result that cannot be measured simply in terms of "improved," "recovered," or "unimproved."

The so-called teaching hospital may measure its achievement primarily by the number of medical students that are graduated each year, the number of nurses trained, and the number of residents and interns for whom graduate training is provided. It must, how-

ever, also evaluate its services to the patients discharged in the same year.

The smaller hospital in its own locality may, should, and usually does give its services in many ways that cannot be calculated in terms of improved and unimproved.

Standardization

We have in the Hospital Standardization Program of the American College of Surgeons an effort at an accounting system applicable to all hospitals. For years the only organized and sustained program has been carried out by that body, but it is primarily an effort at standardization at an increasingly high level. Father Schwitalla has, however, pointed out the difference between "standardization" and "the maintenance of individuality amidst uniformity."

There are, of course, the figures that must be worked out for all hospitals: the discharges for each of the various services, the average length of stay for each of these services, the deaths from various causes, the percentage of autopsies, the types of operations performed with end results and complications, the number of live births, the number of anesthetics by various agents, the number and type of special laboratory procedures. These are, however, essential and routine figures, or, if you will, professional bookkeeping.

Comparison of these with similar details of previous months or years gives merely an index of what is being done in the hospital.

A professional audit applied to the individual staff member has been suggested as a means of evaluating the services rendered by him, with the idea that this can also serve as a check on his ability and can even be used as a basis for disciplinary purposes.

In some hospitals, the professional accounting system includes the tabulation of the hours each day devoted by each staff member to various procedures in the hospital, as well as enumeration of procedures and conferences, and this is applied particularly as a measuring stick for the evaluation of interns and residents. Again, this is merely detailed bookkeeping which, by the compilation of such data, tends more toward the regimentation of men and services than to the attainment of any professional improvement.

We still have arrived at no agreement as to what should constitute professional accounting and how to apply it to our hospital records. We do realize that with the larger variety of hospitals and points of view concerned, it will be impossible to work out a formula that can be applied to all case records. In specialized hospitals the problem is not so difficult. Since 1908 the National Anti-Tuberculosis Association has provided a classification for admissions and discharges to tuberculous institutions. To find such a system to apply to a hospital with twenty separate and distinct services is a totally different problem.

Moreover, at one time our interest may be the desire to check a series of patients treated in one manner against a similar group of patients treated by another method. At another time it is necessary to study the end results of one operative procedure as compared with another. Or an epidemic may sweep through a hospital, and a study is required to forearm against a similar episode.

It is the study of patients' records to establish clinical values that we should call professional accounting. You cannot have attended any series of scientific sessions without realizing that you are listening to and learning from the experiences that have been compiled in the form of patients' records. While they are brought into the realm of accounting because very often long and detailed studies of figures are involved, the records are still professional records.

The Hospital Technicians

Professional accounting should consist of clinical studies based on sound clinical observations made by trained clinical observers. Physicians have surrounded themselves by laboratory technicians, radiologists and cardiologists, and rightly so. In this manner only can their services be stretched as they have had to be in recent years by the demands put upon them. The tuberculosis specialist carries on his work with a roentgenogram, the product of a technician; a sputum report, the product of another technician; a

differential blood count and a blood sedimentation test, also produced by a technician. But if our practice is to be carried on in that manner only, then the art and science of medicine are both going to suffer immeasurably. And now we see the development of another technician—the record librarian.

Again the reason is obvious. The handling of records can be boring, but better, more useable records will be the result if a trained person will take on that duty and see that diagnoses, primary and secondary, are properly coded and procedures coded.

This technician's work, however, can be effective only if the records from which the data is abstracted—the history, the progress notes, the clinical observations and diagnoses—are all made in a systematic manner and a nomenclature that is followed throughout the hospital is used. This can be done only by the interested and painstaking physician who must make himself, and nobody else, responsible for the clinical value of the records.

Then indeed, professional accounting can be applied in such a manner that the hospital, the physician, and primarily the patient will gain.

Hospitals and the Selection of Medical Staffs*

By MR. J. W. HOLLOWAY, JR.
Chicago

J. W. HOLLOWAY, JR.

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A HOSPITAL has many functions to discharge. It should, of course, provide modern facilities by which scientific medical care can be delivered to the sick whose condition requires treatment that cannot be rendered at their homes or in the offices of their attending physicians. It should serve, too, as an educational institution. It is an institution in which general internships may be served by graduates of medical schools, in which specialized experience can be had after internships, and in which training may be given to nurses. It is an institution in which, through staff meetings, difficult and obscure cases are verbally dissected and autopsy findings are analyzed, thus affording a means for the expansion of medical knowledge.

Success Depends on Selection of Staff

In a large measure, the success or failure of a hospital effectively to discharge these functions depends on the care exercised in the selection of medical staffs, for the quality of such staffs will be reflected inevitably in the functioning of the hospital. The term "medical staffs," incidentally, is used in an all-inclusive sense, embracing all physicians who practice in the hospital.

The importance of maintaining high standards in hospitals, particularly in relation to medical staffs, has been given recognition by the courts on numerous occasions. Those closely associated with the active administration of hospitals have necessarily an intimate interest in guiding the progress of their institutions along courses that will eventuate in the greatest public good. No less concerned are physicians generally in instrumentalities utilizable in the rendering of good medical care and in the advancement of scientific knowledge. The activating impulse in each group should be, and in most instances is, the desire to serve the ultimate good of the patient.

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Cases Involving Selection of Medical Staffs

The most recent case involving the selection of medical staffs arose in the State of Illinois.[1] This case concerned a hospital owned and operated by a municipality. One of the rules adopted by the hospital was that no physician could perform a major operation in the institution unless he was a member of the staff or unless he had in attendance at the operation one or more members of the staff. The complaining physician was a member of the associate staff and sought by proper court proceedings to enjoin enforcement of the rule, relying, in part, on a provision in the state law governing the operation of the hospital to the effect that "All physicians who are recognized as legal practitioners by the Department of Registration and Education shall have equal privileges in treating patients in such a hospital." In denying relief to the physician, the court pointed out that the rules adopted were those of standard hospitals and applied to all physicians alike. The particular rule in controversy, the court thought, was fundamentally a provision for the public safety and public welfare, serving to maintain a standard of excellence and proficiency contemplated by the statute under which the hospital operated, and required by the welfare of the public.

In another recent case, decided by the Court of Appeals of Kentucky in 1942, the hospital involved was privately operated.[2] The court in that case upheld the validity of a ruling which in effect limited the practice of certain types of surgery in the institution to physicians having, as described by the court, "the indorsement of the proper board of officers of the American College of Surgeons." There was testimony that the rule was adopted so that the hospital could maintain its accredited status. Such a reason justified the rule, in the opinion of the court.

Osteopaths Denied Use of Hospitals

The Supreme Courts of the United States,[3] the State of Florida,[4] and the State of Colorado,[5] and an intermediate appellate court in Texas[6] have respectively given approval to rules adopted by hospitals forbidding the practice therein of sectarian medicine. In each case, osteopaths sought to compel the governing board to permit them to use the facilities of the institution, and in each case the relief sought was denied. In the Florida case, staff membership in the municipal hospital was limited by a bylaw to graduates of Class A medical schools with a degree of M. D. who were eligible for membership in the county medical society. The bylaw was held valid, and relief was denied to the osteopath despite a provision in the state osteopathic act granting to osteopaths "the same rights as physicians and surgeons of other schools of medicine with respect to the treatment of cases or holding of offices in public institutions."

In the Hayman case, which arose in Texas and was decided by the United States Supreme Court, the state constitution provided that "The legislature may pass laws prescribing the qualifications of practitioners of medicine in this state, and to punish persons for malpractice, but no preference shall ever be given by law to any schools of medicine." The osteopath claimed that because of this constitutional provision he could not be denied admission to the hospital. The court said that the limitation of the constitutional provision was obviously directed to the qualifications of those to be admitted to the practice of their profession in the state and had nothing to do with the qualifications of those who were to be allowed to practice in a state hospital or to participate in an educational enterprise conducted by the state. The ground on which this hospital was constructed and maintained by the city was leased by the state to the city, the lease reserving to the state the right of use of the operating amphitheatre, and the wards and grounds of the hospital by the faculty of the medical department of the State University for purposes of clinical instruction of medical students. In denying relief to the osteopath, the court said that in the management of a hospital, quite apart from its use for educational purposes, some choice in methods of treatment would seem inevitable and that a selection based upon classification having some basis in the exercise of the judg-

ment of the governing board was not a denial of the equal protection of the laws.

Other courts in other states have given recognition to the general principles applied in the foregoing cases. That has been true in Wisconsin,[7] in South Carolina,[8] in New York,[9] and in Idaho.[10]

In Tennessee, the Supreme Court has denied the right of a municipal hospital to exclude from staff membership a physician whose conduct in the opinion of the hospital board was unethical.[11] In a Maryland case, the validity of amendments to the constitution of a hospital was involved.[12] The court held that in a suit to enjoin the members of the staff of an emergency hospital from interfering with a physician's right to practice surgery in such hospital, a court of equity has jurisdiction to pass on the validity of amendments to the constitution of the hospital, which resulted in the denial to the physician of the right to practice in the hospital.

Staff Has Right to Determine Qualifications

A possible complication that may arise in connection with the exercise of the function of selecting hospital staffs is illustrated by a case that came before the New York Supreme Court last May.[13] In that case the board of a private hospital had adopted rules which resulted in the exclusion of a physician from the hospital. He thereafter instigated the return of an indictment against the members of the medical council of the hospital at whose suggestion the rules were adopted, charging them with conspiracy to prevent another from exercising his lawful trade or calling. The court could find no evidence of a conspiracy and dismissed the indictment, holding that the directors of the medical staff of a private hospital corporation have the right to determine the qualifications to be demanded of physicians who use the hospital.

Civil Liability

Doubt may well be expressed that, as a rule, a hospital incurs any civil liability by reason of injuries sustained by patients due to the fault of an attending physician who utilizes the facilities of the hospital in rendering treatment, provided, of course, the physician is acting in the capacity of an independent contractor. One case has come to my attention in which a hospital was declared civilly responsible, even though the practitioner had no connection whatsoever with the hospital.[14] The term "practitioner" is used advisedly, for the person involved was not a physician. He was a layman functioning without benefit of license. This layman, using the facilities of the hospital, applied a paste to a sore, allegedly cancerous, on the lip of a truck driver and permitted the paste to remain on the lip for some twenty-one days. When the "patient" left the hospital fifty-nine days after admission, the flesh of the lip and chin had been eaten away. In fact, there was no lip or chin left, and all his teeth had fallen out. Medical experts testified that the treatment administered by the layman was a competent producing cause of the condition.

Suit was instituted against the lay practitioner, against the physician who had associated himself with the layman, and against the hospital, resulting in a judgment of $40,000 against all three defendants. The case eventually came before the Court of Appeals of New York. While the verdict was reversed and a new trial granted for reasons that are of no particular concern here, the court did suggest that the basis of the hospital's liability was the wrongful conduct of the executive manager and superintendent acting within the scope of his authority in affording for pay the use of the hospital and its facilities for the purpose of the commission of acts which constituted tort and a crime in violation of the duty owed a patient.

Criminal Liability

This New York case raises another interesting question, that is, the possible criminal liability of hospital authorities if the commission of acts which constitute misdemeanors or felonies is permitted in the hospital. Illustrations that immediately present themselves are the hypothetical cases in which the hospital knowingly permits a physician or other person to perform criminal abortions in the institution or to obscure fingerprints or perform plastic surgery for the premeditated purpose of enabling a criminal

to escape detection. In such hypothetical cases, criminal responsibility would seem to be fairly certain. Again, there are hospitals which permit the use of their facilities by limited practitioners. Assume in such a case that the practitioner, with the knowledge and consent of hospital authorities, performed certain acts in the hospital in connection with the treatment of a patient that were beyond the scope of his license, such as major surgery or the utilization of drugs; then can it not be reasonably argued that the hospital authorities are in effect accessories to the crime?

Reference has been made to the possibility of civil and criminal liability on the part of hospitals or their agents, in connection with the use of hospital facilities, merely to stimulate the thought that in the selection of medical staffs many possibilities are involved. While in such selection the selecting agencies are primarily concerned with the immediate welfare of patients and with the extension of scientific knowledge, they also may be excused if they act in self protection to avoid legal potentialities.

BIBLIOGRAPHY

1. *Selden v. City of Sterling et al.*, 45 N. E. (2d) 329. See also *The People v. The Julia F. Burnham Hospital*, 71 Ill. App. 246.
2. *Hughes v. Good Samaritan Hospital et al.*, 158 S. W. (2d) 159.
3. *Hayman v. City of Galveston et al.*, 47 S. Ct. 363, 273 U. S. 414.
4. *Richardson v. City of Miami et al.*, 198 So. 51.
5. *Newton v. Board of Commissioners of Weld County*, 282 P. 1068.
6. *Harris v. Thomas et al.*, 217 S. W. 1068.
7. *State ex rel. Wolf et al. v. La Crosse Lutheran Hospital Ass'n*, 181 Wis. 33, 193 N. W. 994.
8. *Strauss v. Marlboro County General Hospital*, 194 S. E. 65.
9. *Van Campen v. Olean General Hospital*, 205 N. Y. S. 554.
10. *Lambing v. Board of County Commissioners*, 45 Idaho 468. 263 P. 992.
11. *Henderson v. City of Knoxville*, 157 Tenn. 477, 9 S. W. (2d) 697.
12. *Stevens v. Emergency Hospital of Easton, Inc.*, 121 A. 475.
13. *The People of the State of New York v. Moore et al.*, decided May 7, 1943, by the New York Supreme Court, Orange County.
14. *Hendrickson v. Hodkin et al.*, 11 N. E. (2d) 899.

Interhospital Relations*

By WILLIAM A. COVENTRY, M. D.

Duluth, Minnesota

W. A. COVENTRY

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I AM mindful of former hospital councils, approved by the American Hospital Association, which have been established in large cities such as New York, Cleveland, and Chicago. I shall attempt to show what can be accomplished by establishing better interhospital relations in medium sized cities where there are two or more hospitals, an interrelationship which is of benefit to the hospitals, the physicians concerned, and the public in general.

Previous to July, 1929, our hospitals in Duluth were each running as free lances and without too much concern for each other; at the same time, staff problems arose which were somewhat divergent. Certain leaders in the medical profession secured approval to form an interhospital committee composed of the superintendents of our two leading hospitals, the chiefs of staff of both hospitals, and two other medical men from each hospital whose purpose was to coordinate the practices in both hospitals and to work toward unification of hospital policies as well as unification of the profession. One hospital was Catholic, the other Protestant. It was

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understood from the inception that no controversy should ever arise over any procedures in which religious beliefs or tenets were concerned.

The following are certain, but not all, accomplishments which have been effected in the period that has followed since 1929.

1. In 1929 a careful study was made of the prostatic deaths. It was thought that the incidence was too high, largely attributable to cardiovascular causes. An order was issued that a medical consultation would be required before prostatic procedures could be begun. Later the chief of the surgical department of the staff was required to review the chart and approve the preparation of the patient. This edict certainly created an interest, not only on the part of the urologist, but it also necessitated a critical review of all prostatic procedures with the result that for the last five to seven years we have been much more proud of our mortality records in this procedure. Who benefited? The surgeon, the internist, the hospital and, finally, the public.

2. A second unusual action was prompted by the knowledge that for some time certain professional men had been doing surgery which was far beyond their skill and qualifications and that the results were oftentimes disastrous to the patients. It was deemed by the Interhospital Committee that such practice was not fair to the hospital and, especially, to the patients. A fearless committee was appointed to grade every physician wishing to do surgery into three classes: (1) Those qualified to do all types of surgery or, in the case of specialists, those limited to a specialty such as eye, ear, nose and throat, or orthopedics. (2) Those limited to certain types of surgery. (3) Those limited to only minor surgery. The surgical department of each hospital was to do the supervising, assisted by the chief of the surgical department of each hospital.

Fairness of System Readily Seen

One might think there would be an immediate uproar, but when the matter was fully explained to the staff members, they saw the fairness of it to the public and to the hospitals. Needless to say, this list is confidential to the surgical supervisor of the hospitals and is not known to the public. Every new surgeon coming to the city goes into class 3, even if he has been an established surgeon elsewhere or a graduate Fellow in Surgery, but, of course, when he shows his ability to do surgery, he is readily advanced. We have been surprised by the desire on the part of incoming surgeons to abide by the rules.

If a doctor wishes to operate on a patient whose surgery is in a class beyond his rating, he must have a consultant to assist him. This consultant must be a surgeon in class 1. In about 99 per cent of such cases, this consultant offers his service as a goodwill gesture in his desire to help others. He does not examine the patient; he makes no charge; and the patient does not know that he was present at the time of the operation. This confidence has worked most admirably.

These are the two outstanding contributions of surgery.

Obstetrics

In obstetrics we have been able to keep uniform records in our hospitals which have proved a worthy contribution to obstetric record tabulations and future study, so much so that this obstetric record form has spread to other states. Obstetric consultations have also increased under the guidance of this committee.

Items on Which the Hospitals Have Secured Coordination

All regulations have not, however, been concerned with the physicians. I shall enumerate some of the items upon which the hospitals have secured greater coordination:

(1) Earlier hours of admission for surgical patients so that interns may have the opportunity to formulate proper histories. This procedure is gradually improving.

(2) The use of the Bartlett method of hypodermoclysis.

(3) Abolition of vaginal douches in preoperative preparation because they are ineffectual.

(4) Uniform holidays in surgical departments with regard to posting of operations.

No elective operations on New Year's Day, Good Friday, Decoration Day, July Fourth, Labor Day, Thanksgiving, or Christmas Day.

(5) General propaganda and attempts to standardize sizes and types of suture material and to promote smaller sizes. This has led to a uniform reporting and study of operative infections.

(6) Uniform fee schedules for operating room procedures and anesthetics. Obstetric charges for stated periods of stay in the hospital are based on a flat rate for eight days.

(7) Uniform diet sheets which can be understood by all, regardless of which hospital is concerned.

(8) Uniformity in requests for roentgenograms in obstetrics by posting the various types of requests which were standardized by the radiology departments.

(9) Uniform laboratory charges and requests. There has also been an attempt to control unnecessary laboratory procedures.

Time Limit on Completing Records

Uniform rules have been established making it mandatory to complete hospital records; now all records must be completed by the first of each month. If any doctor is delinquent in five or more records by that time, he is so notified by mail and by public posting. If these are not completed by the fifteenth of the month, he is not allowed the privileges of either hospital and is so notified by the superintendent of each hospital. One might think that this ruling has no teeth and could not be carried out, but I assure you it works, because the teeth have been applied, and it does work!

Also in record work a great deal has been done and is still being done by staff committees on uniform nomenclature of diseases and operations.

Uniform rules have been established concerning inspection of hospital records by physicians and especially by lawyers and insurance adjustors.

All the hospitals employ the same social worker which unifies the records and the efforts of our hospitals to do the square thing by the patient.

We have been able to require on each operative record adequate recording of all sponge counts and also the type of suture material used and where used. All surgical operations must be dictated either on the dictaphone or to a record librarian immediately at the conclusion of surgery, recording not only what was found but what was done or not done at the time of operation.

We have established uniform nursing rules concerning the proper use of "sulfa" drugs, especially regarding sulfathiazole and its possible kidney damage.

Press Relations

Strange as it may seem, the press delights in printing stories about hospitals and their activities. This has been coordinated by referring such items to the Public Relations Committee of our county medical society, and such press reports refer to both hospitals and eliminate individual hospital "scoops."

Through coordinated effort, we have been able to work better with our city health department on orders concerning visitors and visiting hours in our hospitals. At times hospital visitors have been completely barred during epidemics.

We have been able to cooperate with our city public safety committee by allowing them access to home accident records treated in our hospitals; these records are compiled and used for teaching home safety, through the efforts of women's clubs.

Autopsies

We have nine interns in both hospitals. Through the coordinated efforts of the pathologists, a desire for autopsies has been stimulated in both hospitals to a degree that the autopsy percentage often reaches 80, which is the monthly goal. This interest is acute. Within a month, Alaska has been radioed for a permission, and in the same month, through diplomatic sources at Washington, permission from England for an autopsy on a British sailor was obtained. The relations among the interns in the various hospitals is so cordial that they often relieve each other if something important

arises to take one group away for a few hours.

Staff meetings have been arranged whereby they occur, as does also the meeting of the county medical society, on one Thursday evening a month.

One might think from this narrative that everything necessary has been accomplished, but that is not true. Now there seems to be a trend toward greater use of hospital emergency rooms to care for all kinds of accidents and sickness at unusual hours. We are now attempting to simplify and coordinate these trends, being not unmindful of the tendency of certain hospitals outside of Duluth to render medical service in addition to hospital service. Also, the use of blood transfusions has brought up the question of uniform charges for transfusions and methods of replacement to keep our blood bank up to capacity at all times. Another problem concerns blood alcohol determinations and the diagnosis of so-called intoxicated persons brought by policemen to emergency departments of hospitals.

Our Interhospital Committee is a standing committee, changing from time to time in personnel, always mindful of coordinating the efforts not only of the hospitals but of the physicians practicing in them. This makes for a happy family working for the best interest of us all and all for the patient and the public, which may some day be patients.

It works in Duluth. It can be made to work anywhere. Just try it.

Problems Concerning Graduate Education and Employment of Nurses, Interns, and Residents*

By WILLIAM A. O'BRIEN, M. D.
Minneapolis

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AMONG our problems today in the employment of nurses, interns and residents, perhaps the greatest one is to find someone to employ. Aside from that, the most important essential in good hospital organization is to have standards.

The Organization of the Hospital Staff

Most of our hospitals today follow the practice of organization which is employed by large institutions. In that type of organization each job has certain qualifications, which we try to meet as best we can by means of the people who work in our institutions.

On the other hand, it is impossible for any of us today to find enough people who are properly qualified to fill every position, and many people who were qualified when we hired them or put them into positions of responsibility are no longer maintaining that standard because times have changed. It is for this reason that we need in our hospital organization a consistent policy of reeducation and continued education of our personnel.

Establishment of Medical Centers

We have in medicine certain centers from which new ideas logically come. These centers obviously are designated as teaching

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centers, although they should be called hospital continuation study centers, as they are places where controlled investigation and treatment of disease can be carried out. Our national thinking in this regard is clear.

We no longer employ new drugs without preliminary control measures and observation in a centralized place. Even though penicillin is not a common drug and it is difficult to produce, it would never have been released, even though we had it by the ton, until it had been tried out first in a center.

Not all the practices of the centers are valid practices. Some of them have to be discarded like other practices. But it would seem to be the objective in our thinking to duplicate in every one of our institutions the practices of those places which are called leaders. In many states in the Union this is being done, notably in Maine, where the hospitals belong to an educational group connected with a center.

How the Center Plan is Organized

These centers are built up in Maine with the hospitals ranged around them. If possible, every hospital sends a representative from each major department to Boston each year for a month of training, retraining, or reeducation. During that period when this person is absent from her post, someone else will be making a trip from hospital to hospital taking over these relief positions.

This plan which is being developed by the Bingham Fund in connection with Tuft's Medical College has much in its favor. Naturally, we are handicapped by the war at the present time, but the idea is that in the center a certain practice has been found advisable. The most outlying institution should follow that practice until we develop in our center a new concept of the same problem.

The Use of a Record System

In regard to the matter of records, this is one point which should be reviewed. In no other way can an institution measure its effectiveness in relationship to the center development than by a study of its record system. Not long ago, at the American Medical Association headquarters, I had a chance to talk with Dr. Edwin P. Jordan, the editor of the *Standard Nomenclature*. Dr. Jordan felt that no group, no matter whether it is working in some outlying place or in some central place, should ever feel that it is doing a good job until such a fact is shown in its records.

If the physician is going to measure his professional efficiency, the most important part of the record is, of course, the matter of diagnosis. After all, that is the key of modern medical practice. The matter of diagnosis, then, is reflected in the number and accuracy of the diagnoses on the record.

A recent graduate from a university may make a number of diagnoses as follows: Let us suppose the patient has pneumonia. He will state the fact that the patient has an acute pneumonia which was due to the pneumococcus; he will name the type of pneumococcus; he will name the distribution of the disease within the lung; next, he will tell whether or not the pneumonia was complicated or uncomplicated; and if it was complicated, he will name the complications. Furthermore, if, as a result of specific treatment, the patient developed certain untoward symptoms, these will be recorded and their nature will be classified. Finally, if the patient fails to recover, the diagnosis will include those additional findings or confirmations that are revealed at autopsy.

In other words, the more detailed and specific the diagnosis, as a rule the more recent the connection of the physician with the center; and the farther away we get from this type of thinking, the more inaccurate and less well defined our diagnoses become.

Most physicians feel that the matter of records is simply a nuisance in hospital standardization and administration. Actually, records reveal more clearly than any other medium how well or how poorly the job is being done.

Training the Hospital Personnel

In Minnesota, we have been thinking about this whole question of the training of hospital residents and interns. I think most of us are willing to admit now that the train-

ing of interns and residents is a primary concern of the medical staff. Unless these young men have good use made of their time while in the institution, an important part of their education has been neglected.

We do not grant a man an M. D. degree from the University of Minnesota until he has successfully completed an internship in an approved institution. In other words, for four years in the medical school proper, the medical school has an active supervision of the student. During the fifth year, the job of instructing him is turned over to the hospital staff, which then becomes our educational agency.

In the hospital we make every effort to train our interns and fellows in the methods I have indicated. The records mean much in this regard as evidence of our training program. However, that did not seem enough to us, for after all we have another group of individuals in the hospital federation who are in need of constant training and retraining. I refer now to the hospital personnel.

Minnesota's Center For Continuation Study

Back in 1936, when the University of Minnesota built the Center for Continuation Study, a great many people felt that the idea was not sound. However, the late L. D. Coffman, who was president at that time, had said in one of his reports to the Board of Regents that the idea of having a place where the trained members of society could come and get new ideas and associate with other people doing the same kind of work was a "must" in our educational system.

In 1936, the federal government, which was then having great difficulty in learning how to spend money, gave us an opportunity to submit some ideas. We submitted this one. We included it with the hog barns and chicken houses and other buildings for some departments wanting new buildings, and somebody in Washington plucked out this idea of the adult education unit and approved it.

At that time the only man on the campus who had any idea of what the project was to be like was Mr. Coffman, and he had great difficulty in "selling" the idea to the University staff and administration. He had developed the concept of a center after talking to physicians and ministers and other persons in professional life who, he found, felt that the universities generally had neglected these people following their graduation. In many instances we did not train them in the first place. They were raw material to be processed. Mr. Coffman's concept may be summarized in these three statements:

1. Such a center would disseminate the most recent knowledge available in every branch of human learning.

2. It would stimulate professional interest and growth on the part of our leaders.

3. It would give to the people of the state a higher quality of professional service than they could otherwise expect.

In other words, the extension of medical service to the people represents fundamentally a problem in education. We have the people, we have our institutions, but our people must be trained in the new developments.

The Center for Continuation Study is housed in a building which is a three-story brick structure erected at a cost of $340,000. The government supplied about 40 per cent of this money, and the University the balance. We have a basement garage with enough space to park 250 cars. On the first floor we have a large lounge, library, chapel, dining hall, class room, and administrative offices.

The most important item of education in this field is to get a group of people together who have common interests and common objectives and allow them to live together from three to six days in such a way that they will not only learn from us but will learn from one another.

Minnesota's Plan a Success

The success of Mr. Coffman's program and ideas is evident, I think, for in the past six and one-half years we have had 361 professional courses covering all the fields of human endeavor, including medicine and hospital service, and 16,585 people have come back to school. I think the fact that they have come back indicates that they are

interested in learning more about their subject.

We have had seven courses in Hospital Administration for those who run our institutions, and 500 administrators have spent at least a week with us. We have had seventy-one courses in the hospital specialty field, such as anesthesiology for nurses, dietetics, executive housekeeping, hospital library service, the Kenny technic for nursing, the Kenny technic for technicians, medical record service, medical social service, medical technology, nursing education, nursing procedure, obstetric and pediatric nursing, occupational therapy, operating room nursing, and physical therapy technology. In the last six years, 2,887 hospital people have attended these seventy-eight courses.

Our experience in planning these courses is of interest, for we do not have any program committees. To develop the idea, the University has a small administrative force, consisting of Mr. Julius Nolte and myself. We take an idea which is presented to us and see what we can do with it.

Here is an example. A group of surgical nurses felt that they had some professional problems which were not being satisfactorily answered. We sent out post cards asking them to name three things about their job that they would like to know more about.

The answers came back promptly. The first thing they wanted to know more about was "How can you train a student nurse and keep the surgeon happy at the same time?" That is a problem, but it is a problem which can be solved largely through job analysis. The second question was "How can we be certain that the material we give to the surgeon is sterile?" The third problem was "What new technics in setting up operating room service have been evolved in the last few years?"

As far as the first question was concerned, the answer came, as I stated, from the study of jobs and what each person should perform. To answer the second one, we were privileged to get a man who had checked sterility for twenty years at the Mayo Clinic, Dr. T. B. Magath. The third question represented an inclusion of various hospitals into the program, and each hospital was then asked to demonstrate to those nurses a technic which is being employed in that institution.

An Example of Profitable Reeducation

One of our surgeons had never gone to a certain hospital because he felt he could not get the service that he desired for a certain type of operation. He complained one day when it became necessary for him to go to that institution, because he had ideas of what kind of "muddling," as he termed it, he could expect. Contrary to all his expectations, from the first time he went into the operating room until he finished his procedure, everything was done exactly as he wished to have it done. It was an open reduction of a fracture, and the matter of technic was important. When he was finished, he was so amazed to think that the hospital had at last employed a new person to give such service that he went to the Sister in charge and asked where she had procured her new surgical nurse. She answered, "We haven't a new operating room nurse. We still have the same one, but she attended the course at the University and learned what you men desire today in the open reduction of fractures in the way of operating room technic."

That is what I mean by a reeducation of a person who is competently trained in the first place but, as a result of changes which have come about, is no longer in tune with progress.

We have had some other interesting experiences in dealing with our groups. Most of us have gotten into the habit of expecting a large crowd wherever we go. One attends conventions and hears others saying, "Is there a good attendance?" If the attendance is poor, some want to go home, not wanting to be seen in a place that does not attract a large number of people.

That was one of our problems. Actually, we would rather see ten, earnest, conscientious persons who really want to improve themselves than 100 who simply want to attend for no particular reason except to be seen.

Considerations Necessary in Adult Education

Another thing we have learned is that adults learn slowly. It is not that we cannot learn as we grow older, but everyone connected with adult education is perfectly familiar with the fact that we have found out by experience certain ways of doing things, which in itself represents an accomplishment. If we have to change these ways, it is going to be inconvenient and may not be advisable; consequently, we will be slow to accept new ideas. We have asked all of our instructors to remember this when dealing with adults. Adults do not change easily.

Another rather interesting development in this field has been an attempt to overcome the policy that has prevailed so often in the past of trying to cover too much material. You remember my remarks about the operating room nurse. I named just three subjects. We did not exhaustively cover all of them, but we spent over a day on each one.

Too often our programs for retraining have been broken up into small pieces so that only a smattering of this and that is available for those who would learn. We do not learn that way. We learn slowly. We learn only after being convinced that our position is not the proper one.

The Necessity For Definite Requirements

Another important part of a training program of any sort is to require certain things from those who attend, just as one requires certain things from those who teach. One important part of such a program is to pay for services rendered, to pay for the course, and to pay the instructor. That is not so much a matter of financial gain as it is the placement of responsibility for the effort.

Most of us still have a certain background in our field, and it is a mistake to treat adults as individuals who know nothing. I think the greatest error in teaching is to make people start at the beginning.

Suppose I, as a teacher, stand before a group of physicians or hospital people and say in a pompous way that the cause of tuberculosis is the tubercle bacillus. (It reminds me of the ophthalmologist who arose and said, "A small foreign body in the eye may be very painful.") That is so obvious that we do not get very far in dealing with adults by employing this technic. On the other hand, if we start with a problem which has developed in their particular job, then we will begin to make progress.

In our experience, the ideal programs have been of three and six days each, three days being barely enough to get started, six days being just about enough to get a good start.

The "Retreat" Idea

We have learned, too, that you cannot crowd people; you cannot give them too much at one time. We must go to class for a while; we must see demonstrations for a while; then we must sit down and talk things over. Living together has been our most effective technic. We would rather have a small place where a group of people interested in the same idea can come and live for the three days. This is similar to the famous retreat technic which is so important in certain fields of religion.

In conclusion, it seems to me that medicine as it is being practiced today represents more than just simply hospital standardization. I am talking about medicine in our hospitals. There should not be any difference in the kind of medicine we practice in our smallest hospital and that in our largest hospital. There may be a difference in the ability to carry through to the ultimate completion certain technics, but we think that in the future medicine and hospital administration will come together on this point.

As yet, the American Medical Association does not give us one bit of credit in medical education for giving these hospital courses. We turn in our reports every year, and the *Journal* makes no mention of our work. A few years ago, it did not even use the words "Continuation Study." We adopted that title, which we think is a proper one. We would like to see the complete elimination of such terms as "refresher." Other similar words such as "brush-up," "review," and "institute" are poor expressions, because these are professional attempts.

Last, we would like to see a training program developed in which not only every physician in the state has an opportunity to keep

in touch with new developments in his field but every hospital administrator and every person in the official hospital family is working under that program.

Only when we improve the knowledge and professional practices of the physician and the hospital group at the same time will we improve the practice of medicine.

Attendant Nursing*

By KATHARINE SHEPARD, R. N.
Superintendent of Household Nursing Association
Boston, Massachusetts

THE attendant nurse is not a new figure in the nursing field. Long before there were any schools of nursing, untrained women sometimes referred to as "born nurses" solved the problem of many households with no other resource in illness but a friendly neighbor willing to sit up at night with the patient while the tired family got a little sleep.

This problem was partly settled when hospitals began the education of nurses, but in many cases of mild and chronic illness, there was still a definite need for a person with less skill. This unmet need was recognized by a group of public-spirited women in Boston who decided, over thirty years ago, that the old-fashioned practical nurse could meet this situation and that she should not be allowed to vanish from the earth.

With this end in view, the group opened a registry for practical nurses. Some of the registrants had acquired experience in many years of working with physicians, and others had cared only for their own families in illness. This was really the beginning of the Household Nursing Association School of Attendant Nursing, for the calls coming into the registry showed that in illness the task of keeping the household machinery running smoothly is almost as important as the care of the patient and that the practical nurses were badly in need of instruction in both household economics and nursing procedures.

With the aid of nurses and physicians, therefore, a six months' basic course was planned and given partly in the headquarters of the Association and partly in a hospital. In the twenty-five years of the school's existence, the course has been lengthened to fourteen months and greatly improved, but the basic principle remains the same and carries out the motto chosen by the Household Nursing Association:

"For the Care of Sickness in the Home
For the Care of the Home during Sickness."

Today nursing educators consider the course given by the Association ideal for the training of attendants. It begins in the practice house of the school, where the students spend six weeks before being sent to one of our affiliated hospitals for twelve months of training in bedside nursing. On completion of the hospital training, they return to the central school for a two weeks' senior course.

Cooking

During the first six weeks they are taught cooking, care of the household, and elementary nutrition by qualified dietitians. They prepare their own meals and, under direction, do all the work of the practice house. This part of the course is of great importance to an attendant, as she fulfills only half her function in private duty if she is helpless in the kitchen. Cooking might be taught in a domestic science laboratory or in a hospital diet kitchen, but experience has shown that household training is better given in a practice house where the students go through the daily routine of a well conducted home. The right kind of an instructor can inspire enthusiasm for this part of the student's work and can make her realize how much she can contribute in the home by her skill in cooking and her knowledge of nutrition.

* Presented before the Section on Hospital Relations at the One Hundred Second Anniversary Meeting of the State Medical Society of Wisconsin, Milwaukee, September, 1943.

Wisconsin General Hospital Unit

By HAROLD M. COON, M. D.
Superintendent, Wisconsin General Hospital
Madison

PICTURED on the next two pages is the Wisconsin General Hospital Unit as it appeared at Fort Sill, Oklahoma, early in September, the only picture of Wisconsin's only hospital unit.

The unit was formally approved by the Surgeon General on November 27, 1940, following his invitation to the University of Wisconsin Medical School to form an "affiliated unit."

It was realized that to man completely such a unit would deplete the staff of the Wisconsin General Hospital and the faculty of the Medical School to an uncomfortably low level. Invitations were issued to each of the Preceptors of the Medical School to submit the names of his associated staff that were available for participation, and it was in this manner that Dr. Gale, under the direction of Dean Middleton, set out to fit together a staff that would continue in military service the teaching and human services of the Medical School and the Hospital.

In May of 1942, Dr. Frank Weston took over as director the work so ably carried on up to that date by Dr. Gale and Dr. Middleton, the latter having already left for active service in the Army Medical Corps.

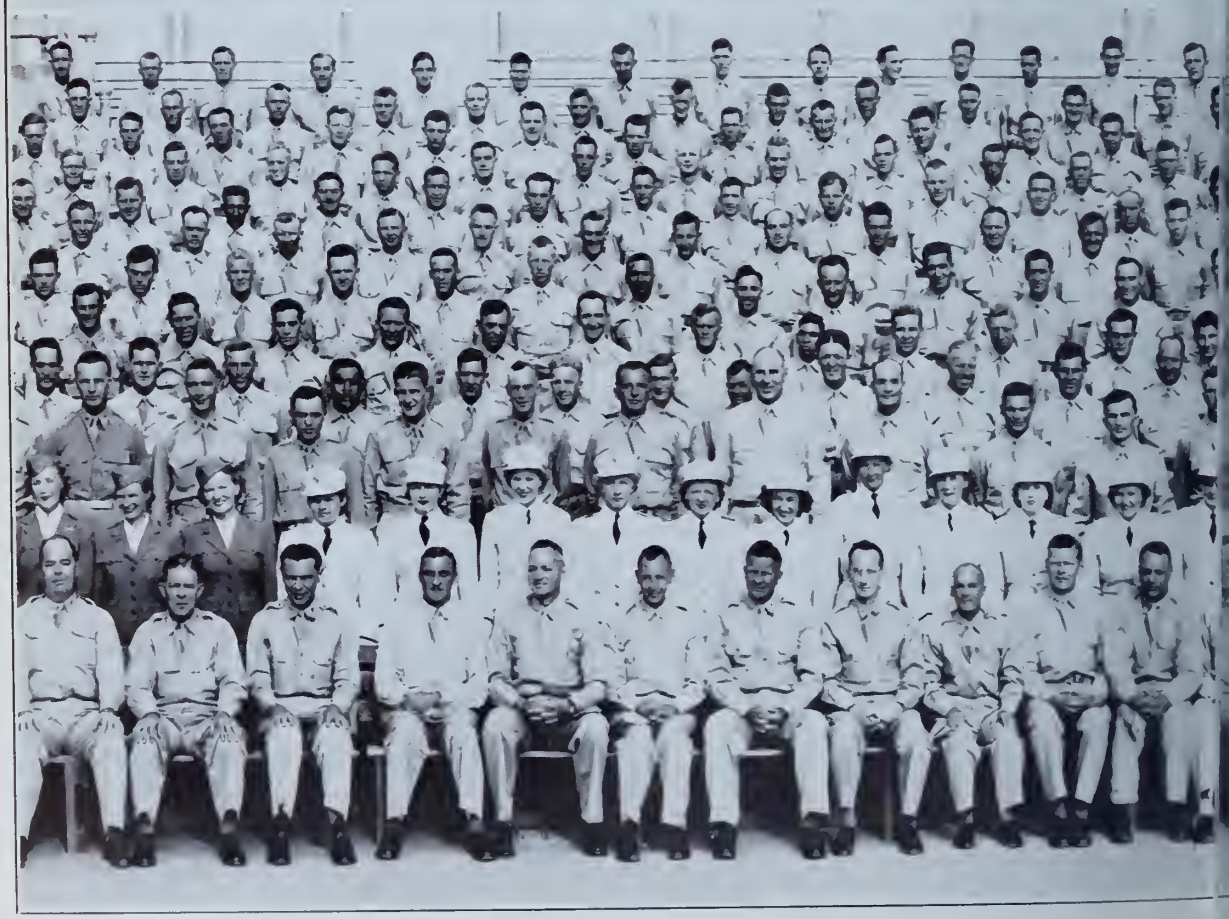
To gain their ground work of military training, the members of the unit volunteered for active duty in advance of their official activation, and by June 15, 1942, most of the men had been assigned to active duty in posts within the Sixth Service Command, mostly at Fort Custer, Michigan, and Camp Grant, Illinois.

Early in 1943, Dr. Weston and about ten other officers were sent to Fort Sill, Oklahoma, and the training of corpsmen assigned by the Army to the unit was undertaken.

At that time, the nurses, who also come mainly from the Wisconsin General Hospital and hospitals affiliated with the preceptor centers of the Medical School, were ordered to report for duty at Camp Anza and March Field in California. Captain Ida Bechtold remained in Madison to continue recruiting service.

In July of 1943, the officers who were at Fort Custer, Camp Grant, and other posts were all sent to Fort Sill for final military training as a complete unit, and most of the nurses were also called to Fort Sill. Colonel Henry Wadell and Lieutenant Colonel Howard Martin of the regular army medical forces were assigned as administration officers, and the unit then had its complete complement of officers, nurses, and corpsmen. The roster of officers and nurses follows, and it is noteworthy that twenty-five of the officers are from the staff of the Wisconsin General Hospital with nine additional ones from the preceptor centers. Of the nurses, seven are graduates of the Wisconsin General Training School, and twelve others have been on duty at that hospital.

The best wishes and hopes of the Medical School, its hospital, and its affiliated hospitals goes with the Wisconsin General Hospital Unit wherever it may be.



ROSTER

OFFICERS

Name	*Rank*	*Arm or Service*
Waddell, Henry G.	Colonel	MC
Martin, Howard C.	Lt. Col.	MC
Weston, Frank L.	Lt. Col.	MC
Bentley, John E.	Major	MC
Daniels, Einar R.	Major	MC
Farnsworth, Richard W.	Major	MC
Goldcamp, John S.	Major	MC
Gordon, Edgar S.	Major	MC
Hochwalt, William R.	Major	MC
Holbrook, Arthur A.	Major	MC
Lemmer, Kenneth E.	Major	MC
McRoberts, Jerry W.	Major	MC
Midelfart, Peter A.	Major	MC
Pessin, Joseph	Major	MC
Richter, Maurice R.	Major	MC
Shapiro, Herman H.	Major	MC
Westover, Edwin F.	Major	DC
Weeks, Frank D.	Major	MC
Birge, Edward A.	Captain	MC
Bingham, James B., Jr.	Captain	MC
Brownfield, Jack D.	Captain	MC
Edgar, Joseph E.	Captain	DC
Esser, William J.	Captain	DC
Gjertson, Chester A.	Captain	DC
Hastings, Walter C., Jr.	Captain	MAC
Hackmeyer, Rubin	Captain	MC
Hawk, Malcolm H.	Captain	MC
Kanzler, Reinhold	Captain	MC
Kohler, Homer H.	Captain	MC
Pohle, Herbert W.	Captain	MC
Prager, Myron S.	Captain	QMC
Pyre, Jackman	Captain	MC
Rogers, Sion C.	Captain	MC
Schott, Edward G.	Captain	MC
Sims, John L.	Captain	MC
Alli, Joseph H.	1st Lt.	SnC
Aronstam, Ralph G.	1st Lt.	SnC
Bennett, Abner P.	1st Lt.	MC
Culmer, Ausmon E., Jr.	1st Lt.	MC
Hayes, James F.	1st Lt.	Ch
Hanni, Walter S.	1st Lt.	MAC
Jones, William E.	1st Lt.	MC
Meyer, Bertrand W.	1st Lt.	MC
Meyer, Ralph R.	1st Lt.	MC
Muilenburg, Teunis H.	1st Lt.	DC
Myers, Myron A.	1st Lt.	MC
Odrowski, Edward A.	1st Lt.	MAC
Peabody, Cary S.	1st Lt.	MC
Tausend, Harold J.	1st Lt.	MC
Teague, Walter E.	1st Lt.	MAC
Willis, Elijah G.	1st Lt.	Ch
Arnquist, Willard D.	2nd Lt.	MAC
Casey, Theodore W.	2nd Lt.	QMC
Dunlap, Isaac L., Jr.	2nd Lt.	QMC
Headley, Francis R.	2nd Lt.	MAC
Kovalich, John G.	2nd Lt.	MAC
Young, Joseph A.	2nd Lt.	MAC
Carhart, Leonard	WOJG	NMB

NURSES

Anderson, Anna B.
Ashlock, Thelma
Ast, Kathryn L.
Auby, Catherine M.
Baade, Rosalie E.
Bates, Luella G.
Bechtold, Ida
Becker, Eda E.
BenBoer, Cornelia J.
Berntson, Ruth E.
Blievernicht, Ruth
Brasch, Ruth M.
Burcham, Esther C.
Coakley, Bertha
Coffey, Marion S.
Hosking, Irene M. Cox
Crawford, Mary L.
Cupery, Dorothy
Dahms, Irene M.
Davy, Margaret M.
Donnelly, Marjorie M. E.
Duddleston, Leone C.
Dunlap, Anne V.
Dvorak, Clara
Egan, Frances E.
Finkh, Evelyn L.
Finnegan, Anida B.
Flory, Mildred M.
Forsythe, Rosemary J.
Fritz, Hilda H.
Gagnon, Cecile A.
Gappa, Kathleen
Gardner, Hope
Gibson, Margaret G.
Ginzl, Wilma L.
Gipford, Vera
Hahn, Dorothy I.
Harness, Catharine M.
Hayner, Clarice A.
Hickey, Helen M.
Hoffman, Hyacinth R.
Howell, Lillian M.
Hunter, Dorothy M.
Hutander, Elsie P.
Joos, Marion S.
Kelly, Grace M.
Killian, Esther M.
Koper, Serapheen
Kosinski, Agnes A.
Koski, Vieno S.
Krause, Kathleen M.
Kreutz, Dorice
Kurkowski, Bernadine
LaDuke, Emily F.
Ladwig, Helen L.
Lawrence, Mary L.
Lee, Dorothy M.
Lester, Winifred
Lutz, Marion J.
Lyon, Lillian A.
Menchoff, Wanda
Miley, Loella M.
Miley, Virginia
Mulrine, Gladys J.
Nelson, Joyce M.
Nugent, Mary E.
Nyblade, Hazel E.
O'Brien, Agnes A.
O'Grady, Sarah J.
Olstad, Myrtle A.
Peterson, Helen L.
Petras, Agnes L.
Pintz, Margaret R.
Pollock, Eda Stalson
Proctor, Alberta A.
Rabideaux, Lucille
Rademacher, Alyce D.
Rahn, Elsebeth
Rasmussen, Mabel J.
Recknagel, Ida M.
Reddeman, Lola A.
Roblee, Dorothy M.
Rodeman, Martha
Sarnow, Martha A.
Scalzo, Leone J.
Schneider, Gertrude
Schnoor Lorraine C.
Schumacher, Elizabeth
Sill, Marguerite E.
Skinner, Ethel
Snyder, C. Maxine
Stebbins, Mary
Stolen, Aleda
Struck, Louise M.
Stuve, Phyllis M.
Sullivan, Agnes P.
Sullivan, Annabelle
Tkac, Alice E.
Turney, Florence E.
Volz, Mrs. Leone J.
Waggoner, Arlene M.
Watson, Shirley R.
Weining, Ruth W.
Whelihan, Agnes
White, Charlotte M.
Winn, Sarah E.
Young, Marjorie
Zibell, Marion

The importance of household training was recognized in Massachusetts when the Approving Authority required in the minimum curriculum six weeks of training in cooking and household care. Other attendant schools are sending their students to us for this part of the course, thus avoiding the expense of setting up the necessary machinery themselves.

Also, during the preliminary course, nurse instructors lay the foundation for the hospital training by classes in elementary physiology and anatomy, care of the well child, and personal hygiene. A great deal of stress is placed on personal relationships, because the attendants seem to need this as much as, if not more than, anything else.

The reasons for including so much instruction in nursing subjects in the preliminary course are to keep up the student's interest, to make her feel that she is not being prepared merely to do housework, and to take some of the burden of teaching from the hospital. The next period is spent in one of our hospitals.

Instruction in Hospital

Each of these hospitals employs a nurse-instructor to teach and supervise the students. Most of the nursing procedure is taught in the first two months, after which the students can give complete bedside care to the patient. The lessons in elementary physiology and anatomy are continued and are followed by lectures on diseases commonly cared for by attendant nurses.

For the final two weeks of the course, the student returns to the practice house, where she is prepared more adequately for private duty. This portion of the course includes electric cookery, experience in planning and buying food, and discussions with nurse instructors of situations which may be met in the home.

The Teaching Attendants

For teaching attendants, the right kind of nurse-instructor is an absolute necessity, and she is not easily found. She must have had teaching experience, but experience in teaching student nurses is not as useful as might be expected, for this group is usually of about the same age and same educational background. On the other hand, in an attendant group the ages may vary from 18 to 50, and the educational background may range from grammar school, often in a foreign country, to business college training. To handle such a group, the instructor must have understanding, sympathy, and adaptability. She must be able to impart information in an interesting way, avoiding technicalities, and must make the students realize their limitations without becoming discouraged.

In some of our affiliated hospitals the physicians on the staff have conducted classes for the student attendants, but this does not work out very well. As the physicians are unaccustomed to using words of one syllable, the students usually leave the classroom in a confused state of mind.

Naturally, physicians who see the student attendant performing the same duties in the ward as the student nurses, and apparently quite as well, may not realize that while the manual dexterity may be equal, the theoretical foundation is entirely different.

Educational Activities Differ

To a student nurse, a bedside clinic or an observation of an operation supplements her textbook knowledge, but it would be a waste of time to give this experience to an attendant, as she is unable to correlate what she sees with any previous instruction. The fact that the student attendant cannot share the educational activities of the student nurse is one of the arguments against training the two groups in the same hospital. It inevitably leads to friction and discontent on the part of the attendant.

This has been proved by past experience. In our early days, our student attendants received their training in the wards of the Boston City Hospital. They complained bitterly that they did only the drudgery. Whenever there was a chance to observe an interesting nursing procedure, a student nurse always ordered them to give a bedpan or push a wheelchair around. If the attendant is trained in a small general hospital where there are no student nurses and where her training is of first importance, she does not suffer from this feeling of inferiority.

Another argument against training the two groups in the same institution is the expense of adding teachers and supervisors, as the regular staff is usually unable to assume an extra teaching burden. Even if this is possible, one group or the other still suffers, because it is difficult to find clinical experience for both beginning student attendants and student nurses.

The Massachusetts General Hospital School of Nursing once considered the plan of adding a school of attendant training. Its superintendent of nurses, on visiting one of our affiliated hospitals, was surprised to find one head nurse running a ward with four attendants and asked who performed complicated and difficult procedures. She was told that in the hospital on that day there were 65 patients and only five difficult procedures: bladder irrigation, intravenous feeding, chest drainage, nasal feeding, and use of the oxygen tent. These could be easily handled by a registered nurse "floater." On asking why there were so few, she was told that patients needing special treatment and a series of tests were usually sent in to her own hospital, the Massachusetts General Hospital. This settled the question, as the trustees realized that in a mixed group of students, some of the technic might inadvertently fall into the hands of the less highly trained worker.

Twenty-Four Weeks' Duty Before Receiving Diploma

A unique feature of the Household Nursing Association is that all attendants are required to do private duty under supervision for twenty-four weeks before the diploma of the school is awarded. The attendants are really graduates and earn good wages during this period. The cases are selected by the Registry to give as much variety as possible, and the attendants are supervised by our staff nurses, who have taught them during the preliminary training, have kept in touch with their work during the hospital training period, and are prepared to guide and help them in the first difficult months of private duty.

We are all agreed on the need of the attendant nurse but are perhaps not in complete accord as to her field of usefulness. The attendant is becoming more important in hospital wards as the number of registered nurses steadily shrinks because of the calls for service with the armed forces. According to the May, 1943, issue of *Professional Nursing,* a recent figure shows that 5,000 more attendants were added to hospital staffs all over the country during the past year. Many duties formerly performed by nurses can safely be carried out by attendants if supervision is given to make sure that the tasks entrusted to them are within their ability.

The Baker Memorial Hospital in Boston, which had always refused to employ attendants, tried out the experiment of using a certain number in each ward. The danger, which is a very real one, of having head nurses in the stress of insufficient help allocate to attendants duties which need special skill is overcome by the rule that permission must be asked of the Training School Office for the attendant to perform any task not specified on her schedule.

Attendant Nurses in Visiting Nurse Associations

Visiting nurse associations have begun to employ attendant nurses and have found them extremely useful in caring for chronic and helpless patients. While the attendants save the time of the nurses, a great deal of their own is wasted in travelling, because the cases with which they can deal are scattered. The director of the Visiting Nurse Association of Boston has one exceptional attendant on duty now but doubts if the rank and file could fit into a visiting nurse program.

Greatest Need in the Home

Though the field of the attendant nurse is widening, the private home has the greatest need for her services, and it is here that she finds her best satisfaction. In the hospital and visiting nurse fields, she is only an auxiliary worker under the direction of the registered nurse, whereas in the home she is supreme and has the satisfaction of meeting a need for which her training has amply prepared her and which no one else can fill as well.

The young mother returning to a servantless home with a new baby, the business woman who must stay in bed in her one-room apartment, the mother who is incapacitated at home and needs care and someone to keep an eye on the children, the chronic invalid, and those convalescing from operations—to all these people the attendant nurse is invaluable. The highly trained nurse would be wasted in such situations and, of course, in these days is unobtainable.

Last winter a doctor on our advisory board said, in speaking of attendants, that the recipe for training them is similar to a recipe for rabbit stew. First, one must "catch the rabbit." Recruitment of attendants is certainly an almost insuperable problem today. Whole pages of our daily newspapers are filled with bold type advertisements begging women to accept large wages while learning a trade. Against all this, we must offer hard work, uncertain hours, and comparatively low pay. However, there is a sure future in attendant nursing and a life of usefulness with enduring rewards which will continue when factories are no longer clamoring for women to take over men's work. There must be many women who would find more satisfaction in caring for people than for machines if they could be made to feel how desperately they are needed. So far, there has been no organized recruitment of attendants, which will be necessary if the gaps in nursing are to be filled.

While it is impossible to compete with industry or the glamor of the WACS or WAVES, it may be worthwhile to base an appeal for attendant nurses on patriotism and to give them, if not a special uniform, a chevron or arm band to show the public that they also are a part of the war program and filling an important place on the home front.

The whole problem of training and employing attendant nurses has been put aside by the nursing and medical professions because of their preoccupation with other tasks, but now we must get together and give this group the attention and publicity it deserves.

INDUSTRIAL HEALTH BOOKS AVAILABLE AT MEDICAL LIBRARY SERVICE

Members of the Society may obtain any one of the following text books on industrial medicine and hygiene by writing to the Medical Library Service, University of Wisconsin Medical School. Also available are periodicals on industrial medicine and hygiene.

Dublin, Louis I.—"Occupation Hazards and Diagnostic Signs"—a guide to impairment to be looked for in hazardous occupations, 1933.

Henninger, Charles H.—"A Survey of Industrial Mental Hygiene"—compiled under the auspices of the School of Medicine of the University of Pittsburgh, 1934.

Heiser, Victor—"Do Good Working Conditions Pay?"—an address by Dr. Victor G. Heiser to the National Association of Manufacturers Congress: a factual summary of health standards and practices in industry today, 1938. 36 pp.

Hueper, Wilhelm C.—"Occupational Tumors and Allied Diseases"—1942.

International Labour Office, Geneva—"Occupational and Health Encyclopedia of Hygiene, Pathology and Social Welfare"—2 volumes, 1930–34.

Johnstone, Rutherford T.—"Occupational Diseases"—diagnosis, medico-legal aspects and treatment, 1941.

Kessler, Henry H.—"Accidental Injuries"—the medico-legal aspects of workmen's compensation and public liability, 1941.

Lanza, Anthony J. and Goldberg, Jacob A.—"Industrial Hygiene"—by various authors, 1938.

Lanza, Anthony J., Editor—"Silicosis and Asbestosis"—by various authors, 1938.

Mack, Mrs. Mary Graham—"Medical and Legal Aspects of Tuberculosis as an Occupational Disease and as an Accidental Injury"—1938.

Sappington, Clarence Olds—"Medico-Legal Phases of Occupational Diseases"—an outline of theory and practice, 1939.

Schwartz, Louis—"A Textbook of Occupational Diseases of the Skin"—1939.

Trudeau School of Tuberculosis, Saranac Lake—"Tuberculosis in Industry"—report of symposium held at the Saranac Laboratory for the study of tuberculosis, June 9–14, 1941. Edited by Leroy U. Gardner, 1942.

Wisconsin Industrial Commission—"Physical Examinations of Industrial Workers"—1939.

"Yearbook of Industrial and Orthopedic Surgery," 1940 and 1941.

Comments on Treatment

Editors—A. J. QUICK, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

The Barbiturates Again and Again

An extensive period of accumulated clinical experience in the uses of barbituric acid derivatives has revealed the occurrence of certain occasional bizarre reactions, the existence of which should be constantly kept in mind.

In the first place, it must be remembered that any drug that will depress a patient to the stage of hypnosis must be well on the way to effecting other and undesirable actions. One of the very common complaints of clinicians is that after a patient has used a barbiturate a few times, instead of falling into a sound and restful sleep so much to be desired, he becomes restless, appears to float about as in a semitwilight state of mind, and finally arouses to feel less rested than before. A change to another member of the series may for one or two administrations yield better results, but not for long. The temptation naturally is to increase the dosage. The amount of drug required to effect a restful sleep is actually increased because of the partial tolerance which has been developed, and along with this tolerance development, clear-cut abstinence symptoms have been seen. Altogether there is found here the bases of true addiction, which does develop, even though frank cases are but infrequently reported.

The recent popularity of continuous intravenous injection of pentothal sodium also calls for caution. It has been established that this ultrashort-acting barbiturate is ultrashort in action at first. On continuation, for a couple of hours, for example, the patient may be depressed for many hours as if he had received a long-acting barbiturate. This clinical course of events can be very easily duplicated in the dog, which establishes this peculiarity as basic, and not of mere idiosyncratic, responsivity. Recently an instance of the unusual was related to the writer in which case a dosage twice the usual size was given, and without producing anesthesia. Another anesthetic was then used, from which the patient recovered promptly as expected. After a short time a delayed depression set in which lasted for several hours and resembled the effects of an overdose of a long-acting barbiturate. This unusual case may well illustrate a basic similarity to the symptom complex observed occasionally after continuous intravenous infusions of the drug.

To date no satisfactory explanation of these peculiar reactions has been made. A. L. T.

AMERICAN BAR ASSOCIATION ADOPTS RESOLUTION OPPOSING WAGNER-MURRAY-DINGELL BILL

"*Resolved*, That the Board of Governors be requested to immediately appoint a special committee to study, analyze and investigate Senate Bill 1161 and that the Board of Governors give publicity to the recommendations and findings of such special committee and the action of the Board of Governors taken thereon; be it further

"*Resolved*, That the House of Delegates is opposed to any legislation, decree or mandate that subjects the practice of medicine to federal control or regimentation beyond that presently imposed under the American system of free enterprise."

Adopted by House of Delegates of The American Bar Association August 26, 1943.

The Nation at War

In this section of *The Journal,* to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Availability of Blood Plasma in Wisconsin

The Office of Civilian Defense, in cooperation with the United States Public Health Service, the American Red Cross, and other agencies, has developed an extensive storage of blood plasma in Wisconsin which is available for civilian disaster, whether originating as a result of enemy action, sabotage, or floods, train wrecks and similar catastrophes.

Experience obtained as a result of the Cocoanut Grove fire indicates that physicians and hospitals must be very alert to the availability of blood plasma in close proximity to them. That physicians and hospitals in Wisconsin might know the location of Civilian Defense dried blood plasma and liquid plasma, the following information is given:

Dried Plasma

Madison—200 units available through J. S. Supernaw, M. D., State Chief of Emergency Medical Service.

Oshkosh—100 units available through A. G. Koehler, Assistant State Chief of Emergency Medical Service.

Eau Claire—100 units available through F. G. Anderson, M. D., Assistant State Chief of Emergency Medical Service.

Superior—100 units available through V. E. Ekblad, M. D., Assistant State Chief of Emergency Medical Service.

Liquid Plasma

Milwaukee—500 units at Columbia Hospital available through Harry C. Sargent, M. D., Milwaukee County Chief of Emergency Medical Service.

Superior—250 units at St. Mary's Hospital available through V. E. Ekblad, M. D., Assistant State Chief of Emergency Medical Service.

Eau Claire—250 units at Luther Hospital available through F. G. Anderson, Assistant State Chief of Emergency Medical Service.

An additional 200 units of dried plasma is in the process of distribution, and it is anticipated that some will be sent to the following as soon as the county chiefs supply the Office of Civilian Defense with the necessary information.

Beloit	20 units
Fond du Lac	20 units
Kenosha	20 units
Manitowoc	20 units
Racine	20 units
Sturgeon Bay	20 units
La Crosse	20 units
Janesville	20 units
Waupun	20 units
West Bend	20 units

Jungle Clinic Aids Unstrung Soldiers

Near Port Moresby is a station hospital which serves as a clinic for treating soldiers suffering from what physicians call "war neuroses." The soldiers come both from the rear areas and the front lines. Those from the front were described in the last war as "shell shocked"; in this war, the soldiers' term is "bomb happy." Those from rear areas correspond to emotionally upset persons in civilian life called "psychoneurotics."

The clinic has five psychiatrists whose sole work is treating the spirit—that nebulous thing called morale—rather than physical injuries or diseases. The clinic is the only one in the southwest Pacific area and one of the few anywhere for American armies in combat zones.

The idea of a special hospital section near the front to treat soldiers of this type is new. The results have attracted the attention of high officers in the medical department of the Army who have made special trips to visit the clinic.

These soldiers are war casualties as much as a soldier shot in the leg. The terrible sights and noises at the front, piled on their mixed fears, doubts, and ideals when they are exhausted and hungry, are too much for them. Or resentment, homesickness and worry—which flourish in the monotony of rear area army life—may be the cause. The men do not realize what has happened to them, and that adds more fear and worry.

They need help to get adjusted again. And the psychiatrists at the clinic give it to them. In the eyes of the patient, the psychiatrist is more of a friend, adviser, and teacher than a physician, for he seldom gives them any medicine. All he does is talk, give them things to read, and make them play and work.

The success of the clinic is indicated by the results. The psychiatrists have been busy from the start. More than half of the patients have gone back to full duty, including many who returned to the front. Half of the remainder are doing useful work in rear areas. About 80 per cent of those sent back to duty arrived at the clinic in a state de-

scribed as "anxiety tension." About 40 per cent of the war neuroses patients treated during the Buna campaign came from combat. The other 60 per cent had not been within 100 miles of the Japanese lines.

The special clinic devoted to this work enables many soldiers with war neuroses quickly to regain control of themselves and helps them to adopt an outlook and technic of living which makes them good soldiers again, with promises of a happy, normal life after the war. Many probably would recover in time, psychiatrists say, but helpful guidance makes their recovery quicker and more nearly complete. They believe that in many cases the early help of an understanding psychiatrist prevents the tragedy to the individual and society which results when a returned soldier spends the rest of his life in a veterans' hospital.—Condensation of an article written by Robert J. Doyle on September 23, Somewhere in New Guinea.

Military Notes

J. G. MacKENZIE

Lieutenant J. Grant MacKenzie, 33, of the Royal Canadian Air Force was killed September 5 in a plane crash in Newfoundland while making a flight in checking his findings in research on aviation medicine. A Canadian by birth, Lieutenant MacKenzie had returned to his home country to enlist in the Royal Canadian Air Force after having been a member of the Davis and Neff Clinic, Madison, where he had been in charge of the ear, nose, and throat department for a year.

Born in Lucknow, Ontario, Canada, he was graduated from the School of Medicine, University of Toronto, in 1936. After interning for two years at St. Michael's Hospital, Toronto, he took a three-year postgraduate course at the New York Eye and Ear Infirmary. In 1941, he was graduated from Columbia University, New York City, where his contribution to medical science was considered vast. He then pursued his studies in Philadelphia, after which he assumed his position in Madison.

Joining the R. C. A. F. on July 6, 1942, he attended the School of Aviation Medicine, was assigned to St. Thomas Technical Training School as a surgeon, and on December 8 went to Toronto No. 6 I. T. S. to work as a consultant.

Surviving him are his widow and a young daughter, who was born to them about three months after Lieutenant and Mrs. MacKenzie left Madison.

Lieutenant Commander Donald C. Wilkinson, Oconomowoc, is now on active duty with the United States Navy at the Navy Yard, Mare Island, California, where he reported for service on September 27, 1943. He was formerly a member of the Wilkinson Clinic, Inc., Oconomowoc.

T. A. LEONARD

Lieutenant Commander Thomas A. Leonard, Madison, a member of the Committee on Medical Economics and Voluntary Sickness Insurance of the State Medical Society, is now located at the Navy Hospital in Oakland, California, his first assignment in service. From 1933 until his departure for duty on October 11, he was associated with Dr. Homer Carter in the practice of obstetrics and gynecology. He was accompanied by Mrs. Leonard.

Frequently mentioned in Frank D. Moran's new book, "Pick Out the Biggest," is **Lieutenant H. L. Baxter**, Neenah, of the United States Navy. Portraying heroism, danger, thrills, and horror, the book deals principally with the twenty-seven minutes during which the cruiser *Boise* sank six enemy ships off Guadalcanal. One of the things which the author has to say about Lieutenant Baxter, one of but three ship physicians aboard, is that he "couldn't be dragged from the navy with a Diesel tractor."

Lieutenant Frank K. Dean, Madison, is on assignment with the medical corps of the Navy at Alameda, California. Accompanied by Mrs. Dean and their two young sons, Jeffrey and Thomas, he left Madison to report for duty on September 27.

The present location of **Captain F. C. Lane** of the United States Army is the Mayo Foundation, Rochester, Minnesota, where he will complete a three month's course in surgery. Captain Lane was formerly of Merrill.

In a letter to the *Journal* dated September 29, **Lieutenant Robert S. Wright**, Racine, tells of his assignment at the United States Naval Ammunition Depot, Crane, Indiana, as follows:

"I have recently entered the service and wish to continue to receive *The Wisconsin Medical Journal.*

"Perhaps a few lines of where I am and what I am doing might be of interest to my friends in Wisconsin.

"This is the world's largest ammunition depot covering 110 square miles of beautiful landscape that formerly was a State Park.

"I am the depot surgeon and my duties include doing any surgery that might be necessary on the navy personnel, taking care of the injuries of the civilian and naval personnel, and examining applicants for civilian jobs."

Captain Oscar G. Moland, Augusta, informs the office of the Society of his change of address from Camp Bowie, Texas, to Camp Van Dorn, Mississippi. He expresses his appreciation for the issues of the *Journal* and the various news letters which have followed him in his army travels and given him news from Wisconsin about the "boys both at home and abroad."

Lieutenant Commander James P. Conway, Milwaukee, is in charge of epidemiology for the Fifth Naval and Marine District with headquarters at LeJeune, North Carolina, and has been making an extensive study of the cause, treatment and prevention of malaria, dysentery, and other diseases which threaten the health of America's Army and Navy. On furlough recently at his home in Milwaukee, he stated that because the army that licks malaria will lick the tropics, American sailors, marines, and airmen, and members of the infantry and cavalry are all being taught precautionary measures against malaria, the dreaded disease which is taking more men than are the Jap snipers.

To date no full preventive measures against malaria have been discovered, but both the Army and the Navy are using suppressive treatments which keep men on their feet but which, however, do not act as a curative. In the fight against the ravages of malaria, atabrine, a synthetic product, is being used in place of quinine, of which there has been little supply left since the Japanese drove through the Dutch Indies. Lieutenant Commander Conway considers atabrine to be quite satisfactory, although not a complete duplicate of quinine. The Army and the Navy are making a thorough study of all tropical diseases, and both have set up epidemiology stations all over the world to fight the war of epidemics while airplanes and tanks fight the human enemies.

All men returning from the front undergo thorough examinations for malarial symptoms and other diseases, said Lieutenant Commander Conway. He added that the incidence of the disease is high, and that in some cases men have been found to develop malaria as long as nine months after their return from the tropics. Because the symptoms of the disease often simulate the symptoms of other illnesses, malaria often proves confusing. Moreover, there are many types of the disease, some of which are harder to cure than others.

While in Milwaukee, he attended the One Hundred Second Anniversary Meeting of the State Medical Society and expressed great interest in the work of Dr. Marcos Fernan-Nunez, professor of pathology and bacteriology at Marquette University.

Lieutenant Commander Conway himself prepared an exhibit telling the whole story of malaria which he showed recently in Philadelphia to the Association of Military Surgeons.

From **Lieutenant Roman E. Galasinski**, formerly of Milwaukee, comes the following communication to the office of the Secretary of the Society:

"Regretted so much that I could not attend the annual convention, but I hope that my telegram arrived in time to check me in at least for a proxy attendance. I leave the corporeal representation to the alternate delegate, W. L. MacKedon, M. D.

"Wish to express my appreciation for the *Journal* that reaches me regularly. According to the August edition, you had a fine program organized for this year's convention.

"Recently I had the pleasure of welcoming Dr. B. Churchill to this area. It was grand to meet someone from home, and we had a fine reunion.

"It is almost a year now since I have seen Wisconsin. Hence, a few nights ago when thinking of this fact—and the convention—and the thought that now there is the approach of a change of season with all its beauty and transformation of nature—and a few other things—I fell to reflecting and painting a picture with words, which resulted in a verse that I am taking the audacity to enclose in this letter. I'm sure it speaks for thousands of boys and men away from home—no matter where they are. If you find it worthy enough for the *Journal*, I'd like to feel that in a small way I speak for these many others away from home."

PALM TREE REVERIE

"There's a humming through the palm trees here tonight—
And the diamond studded heavens cast an aqua blue soft light.
There's a beauty that is soothing, like the fragrance of a flower,
Yet my heart keeps seeking elsewhere at this magic quiet hour.

"There's the silhouette of palm trees 'gainst the sky.
There's the foam of ocean's waves floating high.
There's the surge and splash of surf on the beach's graceful shore,
Yet my heart keeps seeking elsewhere evermore.

"In my mind's eye there's a picture of some blushing maple trees.
Of some crisp and ruddy oaks swayed by tempered cooling breeze.
There's the shimmer of the silver birch that twinkles in the sun
And I see the leaves drift gently downward—slowly—one by one.

"I can see the fields of green slowly lose their glossy sheen
And transform to quilts of golden brown, as the light shines in between,
The stacks of wheat bundled so neat and tents of corn stalks row on row.
Yes, that is what my heart is seeking—that is where it wants to go.

"To the Fair Land of Wisconsin, there is where I want to go!
Where the seasons change and autumn sets the earth for winter's blow.
Where the glaciers gouged out lovely lakes and left them here and there
Supplied with springs and ringed with pines that perfume the air.

"Oh tropic skies, enchanted isles, as beautiful as you are
I cannot woo—for my true love is from here very far."

New to the armed forces of the United States within recent months are the following: **Lieutenant Irving E. Schiek**, Oneida, located at Carlisle Barracks, Pennsylvania; **Lieutenant W. A. Adrians**, Hortonville, now at the Navy Yard, Mare Island, California; and **Captain Leonard C. J. Olson**, Delafield, now at Carlisle Barracks, Pennsylvania.

Promotion from first lieutenant to captain is the advancement recently granted to **Captain Harry L. Schwartz**, Kenosha, who enlisted July 2, 1942, and qualified as a flight surgeon the following October at Randolph Field, Texas. He is now flight surgeon with a marauder bomber squadron in England.

Mrs. Schwartz and their three children are residing in Kenosha for the duration.

Major Philip B. Jorgensen, formerly of Mosinee, is the recipient of a recent promotion from captain to major in the medical corps of the Army. Major Jorgenson entered the service in January, 1940.

Mrs. Jorgenson and their three children are residing in Milwaukee for the duration.

Wisconsin Physicians in Service*

Adams County

Harris, Arthur James, Adams
Shapiro, Harry, Adams

Ashland County

Ansfield, Fred J., Glidden
Harrison, G. W., Ashland
Kreher, J. E., Ashland
Seifert, K. A., Ashland
Weeks, F. D., Ashland

Barron County

Bensman, L. L.
Dawson, D. L., Rice Lake
Hatleberg, E. J., Rice Lake
Schlomovitz, H. H., Barron

Bayfield County

Regnier, W. C., Drummond

Brown County

Bolles, C. S., West De Pere
Cochrane, W. L., Wayside
Denys, K. J., Green Bay
Goggins, J. R., Pulaski
Icks, K. R., Green Bay
Merline, G. B., Green Bay
Mokrohajsky, S. M., Green Bay
Saunders, O. W., Green Bay
Schilling, H. J., Denmark
Schoenenberger, A. P., Denmark
Schoofs, G. E., Green Bay
Troup, W. J., Green Bay
Weaver, D. F., Green Bay
Williamson, C. S., Green Bay

Burnett County

Johnson, P. A., Grantsburg
Sherman, L. F., Siren

Calumet County

Vande Loo, F. B., Brillion
Wagner, A. J., Brillion
Winkler, R. J., Hilbert

Chippewa County

Clauson, C. T., Bloomer
Henske, W. C., Chippewa Falls
Picotte, L., Chippewa Falls
Vaudreuil, W. F., Chippewa Falls

Clark County

Frank, H. A., Neillsville

Columbia County

Brown, Harry E., Portage
Dibble, H. C., Portage
Doersch, E. A., Portage
Dryer, R. B., Poynette
Irwin, W. G., Lodi
Ronneburger, E. O., Cambria
Saxe, Jack, Jr., Portage
MacGregor, J. W., Portage

Crawford County

Shapiro, H. L., Prairie du Chien
Farrell, T. F., Prairie du Chien

Dane County

Allin, R. N., Madison
Atwood, D. C., Madison
Axel, B. J., Madison
Barnstein, Norman, Sun Prairie
Bell, John L., Madison
Bennett, A. P., Madison
Bentley, J. E., Madison
Bingham, J. B., Madison
Birge, E. A., Madison
Bleckwenn, W. J., Madison
Bohorfoush, J. G., Madison
Boner, A. J., Madison
Brindley, B. I., Madison
Britton, D. M., Madison
Brooke, J. W., Madison
Brownfield, J. D., Madison
Connor, J. J., Madison
Cunningham, P. M., Madison
De Salvo, M. F., Madison
Dean, F. K., Madison
Diamond, W. B., Madison
Dietrich, H. W., Madison
Dollard, J. E., Madison
Ellingson, H. V., Madison
Fosmark, C. A., Madison
Gale, J. W., Madison
Gallagher, J. T. F., Madison
Gearhart, R. S., Madison

* To October 1, 1943.

Geist, F. D., Madison
Gordon, E. S., Madison
Greiber, M. F., Madison
Halbert, J. J., Madison
Hawk, M. H., Madison
†Hunt, T. D., Madison
Jackson, Russell, Madison
Jacobsen, R. W., Madison
Joachim, F. G., Madison
Johnson, H. C., Madison
Jones, W. E., Madison
Jorris, E. H., Madison
Joyner, T. H., Oregon
Kanzler, Reinhold, Madison
Keck, E. B., Madison
Kjervik, A. R., Madison
Knecht, E. M., Madison
Kohler, H. H., Madison
Krehl, W. H., Madison
Lappley, W. F., Madison
Larsen, R. B., Madison
Leede, W. E., Madison
Lemmer, K. E., Madison
Leonard, T. A., Madison
Lohmiller, B. D., Madison
Marshall, F. S., Chicago
†MacKenzie, J. G., Madison
McCormick, D. W., Madison
Malec, J. P., Madison
Meyer, B. W., Madison
Middleton, W. S., Madison
Miller, J. E., Madison
Moore, R. M., Madison
Musser, M. J., Madison
Myers, M. A., Madison
Nellen, J. W., Madison
Nelson, E. R., Madison
Okegaki, H. I., Madison
Oosterhous, G. E., Madison
Orr, E. R., Madison
Peabody, C. S., Madison
Pessin, Joseph, Madison
Peterson, L. W., Sun Prairie
Pohle, F. J., Madison
Pyre, Jackman, Madison
Quisling, G. D., Madison
Rendok, John, Madison
Reuter, R. J., Madison
Rogers, S. C., Madison
Rueckert, Raymond, Madison
Seastone, C. V., Madison
Shapiro, H. H., Madison
Sherman, C. F., Madison
Shulman, H. W., Madison
Sims, J. L., Madison
Smedal, A. T., Stoughton
Sprague, J. T., Madison
Swafford, K. P., Madison
Swan, L. L., Madison
Tweeten, J. K., De Forest
Wangeman, C. P., Madison
Wear, J. B., Madison
Weismiller, L. L., Madison
Weston, F. L., Madison
Zantow, F. E., Madison

Dodge County

Bachhuber, E. A., Mayville
Bloom, C. S., Horicon
Hoyer, E. C., Beaver Dam
Kierzkowski, C. V., Beaver Dam
Klepfer, J. F., Waupun
Pearson, J. B., Mayville
Qualls, C. L., Juneau
Temkin, M. M., Beaver Dam
Vetter, E. W., Randolph

† Deceased.

Door County

Leasum, Charles, Sturgeon Bay
Little, W. W., Washington Island

Douglas County

Berg, G. S.
Christiansen, R. E., Superior
Christianson, H., Superior
Hathaway, G. J., Superior
Jerome, Bourne, Superior
Johnson, Fred, Jr., Superior
Leveroos, E. H., Superior

Dunn County

Buckley, C. H., Menomonie

Eau Claire County

Brown, G. F., Eau Claire
Culver, L. G., Eau Claire
Dickelmann, L. E., Eau Claire
Fuson, H. S., Eau Claire
Humphrey, N. R., Brandon
Ihle, C. M., Eau Claire
Kincaid, Charles, Eau Claire
Midelfart, Peter, Eau Claire
Mitchell, M. T., Eau Claire
Noland, O. G., Augusta
Niver, E. O., Eau Claire

Florence County

Cook, Alfred L.

Fond du Lac County

Calvy, D. W., Fond du Lac
Clark, C. J., Fond du Lac
Cole, D. F., Ripon
Dalrymple, R. R., Fond du Lac
Dana, R. L., Fond du Lac
Finn, W. C., Fond du Lac
Eagleburger, L. S., Waupun
Florin, A. C., Fond du Lac
Haseltine, C. P., Ripon
Hull, H. H., Brandon
Hutter, A. M., Fond du Lac
Jones, R. H., Ripon
Keenan, L. J., Fond du Lac
Kief, H. J., St. Cloud
Pawsat, E. H., Fond du Lac
Trier, P. J., Fond du Lac
Twohig, D. J., Jr., Fond du Lac
Waffle, R. L., Fond du Lac
Wier, J. S., Fond du Lac

Forest County

Carroll, G. E., Laona

Grant County

Glynn, J. D., Lancaster
Kelly, W. J., Potosi
Klockow, W. E., Muscoda
Moffett, J. L., Montfort
Schuler, W. H., Fennimore
Rempe, A. C., Cassville

Green County

Bear, N. E., Monroe
Bristow, J. H., Monroe
Brunkow, B. H., Monroe
Kindschi, L. G., Monroe

Green Lake County

Seward, L. J., Berlin
Stone, G. C., Berlin
Regan, D. M., Berlin

Iowa County

Dieter, D. G., Cobb

Jackson County

Lavine, M. M., Melrose

Jefferson County

Burzynski, E. E., Watertown
Claudon, D. W., Jefferson
Hanson, O. H., Fort Atkinson
Harris, J. J., Fort Atkinson
Mallow, H. G., Watertown
Miller, E. A., Watertown
Nowack, L. W., Watertown
Zimmerman, F. H., Watertown

Juneau County

Puttler, O. L., Mauston

Kenosha County

Bennett, W. H., Kenosha
Creswell, C. M., Kenosha
Herzog, P. S., Kenosha
Kleinpell, W. C., Kenosha
Rauen, Leonard M., Kenosha
Schulte, G. C., Kenosha
Schwartz, H. L., Kenosha

Kewaunee County

Burger, R. A.
Dockry, L. E., Kewaunee

La Crosse County

Anderson, P. D., La Crosse
Bayley, W. E. G., La Crosse
Gallagher, F. J.
Gundersen, T. E., La Crosse
Johnston, R. C., La Crosse
Montgomery, S. A., La Crosse
Moran, C. J., La Crosse
Shea, T. E., La Crosse
Wolf, F. H., La Crosse

Lafayette County

Hauge, H. L., Blanchardville
Matthei, L. P.

Langlade County

Lambert, J. W., Antigo

Lincoln County

Lane, F. C., Merrill
Rohde, E. P., Merrill

Manitowoc County

Darby, R. C., Mishicot
Erdman, N. C., Manitowoc
Foley, M. E., St. Nazianz
Gregory, L. W., Manitowoc
Hammond, R. W., Manitowoc
Simenson, R. S., Valders
Wright, P. E., Manitowoc

Marathon County

Callahan, H. T., Spencer
Christensen, H. W., Wausau
Flannery, J. V., Wausau
Green, D. M., Wausau
Jorgensen, P. B., Mosinee
Ludwig, E. P., Wausau
Martini, H. F., Wausau

Marinette County

Boren, J. W., Jr., Marinette
De Salvo, M. F., Niagara
Kingsbury, C. H., Goodman
Koepp, C. E., Marinette
Shaw, R. W., Marinette

Marquette County

Moss, J. G., Westfield

Milwaukee County

Adazhek, E. R., Milwaukee
Adland, Abe, Milwaukee
Adler, Sidney, Milwaukee
Aguirre, M. R., Milwaukee
Appleby, K. B., Milwaukee
Armbruster, J. L., Milwaukee
Arnold, W. G., Milwaukee
Babbitz, A. L., Milwaukee
Babbitz, S. G., Milwaukee
Backus, E. A., Milwaukee
Baker, H. K., Milwaukee
Baker, V. L., Wauwatosa
Bartos, J. A., Milwaukee
Baumann, A. J., Milwaukee
Bechman, Fred, Milwaukee
Becker, Reinhard, Milwaukee
Becker, W. T., Milwaukee
Beffel, J. M., Milwaukee
Benjamin, H. B., Milwaukee
Bergen, R. D., Milwaukee
Berner, C. L., Milwaukee
Biller, J. H., Milwaukee
Birk, B. J., Milwaukee
Black, S. B., Milwaukee
Bloom, Herman, Milwaukee
Bloom, N. B., Milwaukee
Boxer, L. M., Milwaukee
Braddock, W. H., Milwaukee
Brewer, B. J., Milwaukee
Brukardt, H. R., Milwaukee
Bruskewitz, Harold, Milwaukee
Bull, F. A., Milwaukee
Carl, E. F., Milwaukee
Cash, I. I., Milwaukee
Champney, R. D., Milwaukee
Charles, J. D., Milwaukee
Cherkasky, Simon, Milwaukee
Christiansen, W. H., Milwaukee
Chudnoff, J. S., Milwaukee
Churchill, B. P., Milwaukee
Clasen, E. A., Milwaukee
Coffey, W. L., Jr., Milwaukee
Cogan, L. J., Milwaukee
Colgan, J. J., Milwaukee
Collopy, P. J., Milwaukee
Colombo, H. L., Milwaukee
Colvert, J. R., Milwaukee
Conen, W. J., Milwaukee
Conover, J. L., Milwaukee
Conway, J. P., Milwaukee
Cordes, V. J., Milwaukee
Correll, H. L., Milwaukee
Cowan, I. I., Milwaukee
Currer, P. R., Milwaukee
Dalton, R. J., Milwaukee
Daniels, E. R., Wauwatosa
Dohn, H. Philip, Milwaukee
Donath, L. H., Milwaukee
Dorr, R. H., Milwaukee
Doyle, C. J., Milwaukee
Dricken, H. N., Milwaukee
Drozewski, M. F., Milwaukee
Dunker, George, Milwaukee
Eichenberger, C. R., Milwaukee
Eiriksson, Charles, Milwaukee
Evans, S. W., Milwaukee
Fechter, Francis, Milwaukee
Feiman, L. H., Milwaukee
Fein, Norman, Milwaukee
Ferris, J. W., Milwaukee
Fine, J. M., Cudahy
Forney, G. V., Milwaukee
Fox, G. W., Milwaukee
Frackelton, W. H., Milwaukee
Franklin, Emil, Milwaukee
French, G. A., Milwaukee
Friedman, Gerald, Milwaukee
Frisch, R. A., Milwaukee
Fulton, J. W., West Allis
Furlong, J. J., Milwaukee
Galasinski, R. E., Milwaukee
Galgano, Rocco, Milwaukee
Gallogly, J. A., Milwaukee
Garens, R. W., Milwaukee
Gaunt, James, Milwaukee
Ginsberg, Bearl, Milwaukee
Goldman, I. R., Milwaukee
Goodman, P. P., Milwaukee
Goodwin, Frank, Milwaukee
Gorman, J. E., Milwaukee
Gottlieb, Abraham, Milwaukee
Grab, J. A., Milwaukee
Graber, Frank, Milwaukee
Gramling, A. J., Milwaukee
Grimm, J. J., Milwaukee
Grossmann, E. E., Milwaukee
Guardalabene, Vito, Milwaukee
Guepe, J. W., Milwaukee
Gute, E. B., Milwaukee
Gutheil, Douglas, Milwaukee
Guzzetta, M. M., Milwaukee
Hagen, Robert, Milwaukee
Hansher, Ervin, Milwaukee
Hardgrove, Maurice, Milwaukee
Hartman, A. S., Milwaukee
Heil, J. V., Milwaukee
Heinan, F. C., West Allis
Heller, T. A., Milwaukee
Henry, R. B., Milwaukee
Hilger, W. A., Milwaukee
Hiller, R. I., Milwaukee
Hipke, M. M., Milwaukee
Hirschboeck, J. S., Milwaukee
Hitz, J. B., Milwaukee
Hoffmann, Charles, Milwaukee
Holbrook, A. A., Milwaukee
Hollenbeck, S. W., Milwaukee
†Horwitz, J. J., Milwaukee
Houghton, W. J., Milwaukee
Jaastad, L. B., Milwaukee
Jelenchick, E. J., Milwaukee
Jochimsen, M. A., Milwaukee
Johnson, H. W., Milwaukee
Johnson, J. A., Milwaukee
Johnston, T. L., Milwaukee
Judd, R. W., Wauwatosa
Justen, R. T., Milwaukee
Kaufman, L. W., Milwaukee
Keating, D. R., Milwaukee
Kendall, E. T., Milwaukee
Kiefer, Edward, Milwaukee
King, J. J., Milwaukee
Kinsey, J. L., Milwaukee
Klein, M. E., Milwaukee
Kleinhans, H. M., Milwaukee
Klopfer, W. P., West Allis
Kocovsky, C. J., Milwaukee
Kocovsky, E. C., Milwaukee
Kolb, Lawrence, Milwaukee
Kores, A. B., Milwaukee
Kores, V., Milwaukee
Kretlow, F. A., Milwaukee

† Deceased.

Krygier, A. J., Milwaukee
Kuhlman, R. F., Milwaukee
Landis, F. B., Milwaukee
Langmack, W. A., Milwaukee
Leeb, Harry, Milwaukee
Lieberman, Benjamin, Milwaukee
Lindert, Merlyn, Milwaukee
Lochman, David, Milwaukee
Low, N. L., Milwaukee
Lustok, M. J., Milwaukee
Macht, A. J., Milwaukee
Mann, Robert, Milwaukee
Marcus, Robert E., Milwaukee
Markson, L. S., Milwaukee
Marlewski, C. R., Milwaukee
Martens, E. W., Milwaukee
Martin, W. B., Milwaukee
McCabe, J. O., Milwaukee
McCormack, M. T., Milwaukee
McDonald, R. E., Milwaukee
Mellencamp, F. J., Milwaukee
Meloy, George, Milwaukee
Mendeloff, Hyman, Milwaukee
Metz, H. I., Milwaukee
Meyer, K. H., Milwaukee
Miller, L. E., Milwaukee
Mookerjee, M. K., Milwaukee
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Vedder, C. A., Marshfield
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MEDICAL AND SURGICAL RELIEF COMMITTEE

To help quiet the convoy-worn nerves of American merchant seamen, the Medical and Surgical Relief Committee of America has donated to the War Shipping Administration 4,000 capsules of sedatives requested for use in recuperation centers in England and North Africa, reported Dr. Joseph P. Hoguet, medical director of the Committee.

Many seamen resting in War Shipping Administration convalescence posts abroad have manned ships loaded with explosives, many more have travelled through sub-infested waters, and others are survivors of torpedoed merchant vessels, Dr. Hoguet explained. Tense from the memory of grim ocean crossings, from the shock of combat or shipwreck, these men cannot sleep. Some become so restless and upset, they are unable to calm down during the daytime.

According to Dr. Hoguet, doses of mild sedatives, such as those contributed by the Committee, relax strained nerves and ensure a normal night's rest.

This recent gift of the Medical and Surgical Relief Committee is but a small part of the $2,500 total of medical equipment requested by the War Shipping Administration's Medical Division in New York. To War Shipping Administration representatives serving in various foreign ports, the Committee has donated sixteen large emergency medical field sets, at a cost of $140 each. Specially designed by the Committee's medical board, the field set consists of two valise-sized cases for use by doctors for wounded and ill merchant seamen. Its drugs, antiseptics, bandages, sutures, syringes and minor surgery instrument roll equip it for any emergency, Dr. Hoguet pointed out.

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« « « EDITORIAL » » »

From Wisconsin to the Nation

SPEAKING to the National Health Conference held in Washington in July, 1938, Prof. Edwin E. Witte, who served as the Executive Director of the Committee on Economic Security which brought in the recommendations upon which the Social Security Act is based, discussed the participation of states in the proposal for compulsory "health" insurance. He expressed the hope that Wisconsin might have the distinction of enacting the first compulsory "health" insurance law in the United States.

In 1937 such legislation was first offered in Wisconsin. It was presented again in 1939, again in 1941, and again in 1943. Now the nation has it in S. 1161 and H. R. 2861. Senator Wagner characterizes the proposal as "Social Security lifts its sights." In Wisconsin those sights embraced the expenditure of about $33,600,000 yearly to cover approximately two-thirds of Wisconsin's 3,100,000 population with "health" insurance administered with the assistance of probably 20,000 employes.

In the nation the sights embrace well over $3,000,000,000 being given the Surgeon General who would become the monarch of all he surveyed. All physicians should read the analysis of this proposal which appeared in the June 26, 1943, issue of *The Journal of the American Medical Association.* Of particular interest is the statement of the Council on Medical Service and Public Relations of the American Medical Association relative to this proposal printed on page 1178 of this issue of *The Wisconsin Medical Journal.* Wisconsin physicians will be particularly interested to note the marked resemblance between it and the proposals made in Wisconsin.

It appears now that the issue is clearly nationwide. It is not a challenge to the medical profession so much as it is a challenge to the health achievements of this country. If placing doctors in professional parrotry serving in a feudalistic community embraces progress in public health possibilities, thinking citizens are not yet able to understand it. Wisconsin physicians can and must lend their assistance, based upon their own experience, to "Give light, that the people may find the way." C. H. C.

. . . . THE PRESIDENT'S PAGE . . . .

THERE is much discussion of economic planning and the planners. One gets the impression from much of the talking and writing, official and unofficial, that all this is of recent genesis. A moment's reflection will establish the fallaciousness of such thinking.

About the turn of the century, it became apparent to foresighted statesmen in our government that the laissez faire attitude in matters pertaining to the public welfare, physical and economic, was untenable. They planned and directed the movement toward our regulative economy of today. Railroads were the first to be subjected to rules of fair trade practices. Large monopolies in natural resources and manufacturing, insurance companies, and public utilities were subsequently brought under the restraining hand of governmental agencies.

The challenge was met when the equity of such control was recognized by the public, by business generally, and by our institutions, and internal economy went on through World War I and into the never-to-be-forgotten twenties gaining greater and greater momentum until it crashed by virtue of its own velocity's being too great to enable it to stay on the tracks of true economic security.

It became apparent that greater regulation and control was necessary. The planners again stepped into the breach and set up new regulations that are not gainsaid by even the conservatives who are fair and just in their utterances.

The planners were not, however, content with placing stopgaps on bad fiscal and business policies but went far afield until nearly every phase of our social and economic life came under their microscope, which brought into sharp relief much that had been thought and talked about during the preceding two decades but never crystalized—the American way of life.

Delivery of medical care, hospitals, and nursing care became part of the over-all plan to be made subject to governmental control. While much that was applicable to business was subjected to scathing attack by the press, that which pertained to medical practice and hospitals was supported more generally. Many of those who on principle objected to government control of health services are nevertheless supporting a radical change in the distribution of medical care. The net result, therefore, has been the development of potent forces for propaganda and, to a great degree, public acceptance, of schemes that make our present position insecure and vulnerable. Our hapless approach to insurance schemes have helped but little to satisfy the demand for change.

Will we be the planners who will steer medical practice into the safe waters of public regard, or will the National Resources Planning Board or the Board of Post-war Economics or a Wagner Act force us into an uncompromising position? Social planners are nondivorceable from our social structure, as are taxes. If we do not like those who are at present doing the job, we had better get rid of them and try the next group. We may succeed in changing emphasis but never the activity. Social agencies and their methods are too well integrated in our economy.

It is later than we think. We must bestir ourselves on the county, state, and national levels and, by the time the House of Delegates of the A. M. A. holds its next meeting. have a workable pattern ready which will give to the profession some definite tenets and to the public a definite recognition of our sincerity, if together we are to fight off programs that are being formulated not in the interest of the best that American medicine can produce. We must keep medicine attractive to the best young minds to enter as a profession. We must keep physicians unshackled and able to continue to advance medical science to even greater heights. Yet, we must devise a method for delivery of medical care that will make for more equitable and widespread availability of service.

Your State Society is a vital thing, sensitive to your ideas and fully cognizant that medicine, like all disciplines dealing with humanity, cannot be static. You are Wisconsin medicine, and what you want, we, your officers and delegates, will translate into action through trial plans and up to the national level for integration in a national plan. Such trials must become more comprehensive and inclusive to fulfill the postulates acceptable to the proponents of change. It is a tremendous movement, and we, as physicians, must weigh the responsibility of running such agencies or merely controlling the service angle, relegating the fiscal polices and actuarial regulation to agencies well seasoned in the insurance field.

We need definite policies, and they can result only from clear, unprejudiced thinking. Conferences between all parties concerned should be started now to lay the groundwork for definite action. This problem is not a purely medical one; the public has a greater stake than we, since Public Health and Public Welfare are predicated on the outcome of new departures in distributing medical services.

American Medical Association Council on Medical Service and Public Relations

A Statement of General Policies

PURSUANT to carrying out the duties imposed on it by the House of Delegates, the Council has adopted the following general policies:

1. The Council on Medical Service and Public Relations recognizes the desirability of widespread distribution of the benefits of medical science; it encourages evolution in the methods of administering medical care, subject to the basic principles necessary to the maintenance of scientific standards and the quality of the service rendered.

It is not in the public interest that the removal of economic barriers to medical science should be utilized as a subterfuge to overturn the whole order of medical practice. Removal of economic barriers should be an object in itself.

It is in the public interest that the standards of medical education be constantly raised, that medical research be constantly increased and that graduate and postgraduate medical education be energetically developed. Curative medicine, preventive medicine, public health medicine, research medicine, and medical education, all are indispensable factors in promoting the health, comfort and happiness of the nation.

2. The Council through its executive committee and secretary shall analyze proposed legislation affecting medical service. Its officers are instructed to provide advice to the various state medical organizations as well as to legislative committees concerning the effects of the proposed legislation. It shall likewise be the duty of its officers to offer constructive suggestions to bureaus and legislative committees on the subject of medical service.

3. The Council approves the principle of voluntary hospital insurance programs but disapproves the inclusion of medical services in those contracts for the reasons adopted by the House of Delegates at the 1943 meeting.

4. The Council approves voluntary prepayment medical service under the control of state and county medical societies in accordance with the principles adopted by the House of Delegates in 1938. The medical profession has always been very much opposed to compulsory health insurance because (1) it does not reach the unemployed class, (2) it results in a bureaucratic control of medicine, and interposes a third party between the physician and the patient, (3) it results in mass medicine which is neither art nor science, (4) it is inordinately expensive, and (5) regulations, red tape and interference render good medical care impossible. Propaganda to the contrary notwithstanding, organized medicine in general, and the American Medical Association in particular have never opposed group medicine, prepayment or non-prepayment, as such. The American Medical Association and the medical profession as a whole have opposed any scheme which on the face of it renders good medical care impossible. That group medicine has not been opposed as such is evidenced by the fact that there are many groups operating in the United States which have the approval of the medical profession, and members of these groups are and have been officials in the national and state medical organizations. That group medicine is the Utopia for the whole population, however, is not probable. It may be and possibly is the answer for certain communities and certain industrial groups if the medical groups are so organized and operated as to deliver good medical care.

5. The Council believes that many emergency measures now in force should cease following the end of hostilities.

6. The Council believes that the medical profession should attempt to establish the most cordial relationships possible with allied professions.

7. There is no official affiliation between the American Medical Association and the National Physicians Committee. However, since it is the purpose of the National Physicians Committee to enlighten the public concerning contributions which American medicine has made and is making in behalf of the individual and the nation as a whole, it is the opinion of the Council that the medical pro-

fession may well support the activities of the National Physicians Committee ond other organizations of like aims.

8. American medicine and this Council owe a responsibility to our colleagues who are making personal sacrifices to answer the call of the armed forces. Therefore, the Council expresses the desire to cooperate with the medical committee on postwar planning in order to assist our colleagues in reestablishing themselves in the practice of medicine, and in the preservation of the American system of medicine.

The Wagner-Murray-Dingell Bill

A Statement by the Council on Medical Service and Public Relations, American Medical Association

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THE legislation introduced in the United States Senate, June 3, 1943, by Senator Wagner and Senator Murray as S. 1161 and in the House of Representatives by Congressman Dingell as H. R. 2861 proposes radical amendments to the Social Security Act. Others have characterized it as "fantastic in scope, idealistic in objective and extremely expensive in its economic aspect."

The Council reserves judgment on the amendments proposed that are not directly concerned with medical care. Concern must be expressed, however, over the effect on the health of the people of that part of the legislation that undertakes to create a federally controlled system of compulsory sickness insurance to include an estimated 110,000,000 wage earners, self-employed persons and the dependents of both classes. Such a system would be created by section 11, which proposes to amend title IX of the Social Security Act to provide "Federal Medical, Hospitalization, and Related Benefits."

By a revolutionary process, the enactment of section 11 would undermine and destroy the American system of medicine that has developed in an evolutionary, healthful manner over the entire period of the history of medicine in the United States.

American medicine has developed an unexcelled quality of medical education. The enactment of section 11 would break down our system of medical education. It would remove the incentive that stimulates the student to acquire the best medical education obtainable by offering that student a regimented practice, federally supervised and controlled. This result the sponsors of the legislation inferentially apprehend by including a provision for federal grants-in-aid to stimulate medical education.

American medicine has made available to the people an unexcelled quality of medical care. The enactment of section 11 would attenuate the quality of medical care available to the people by imposing on physicians conditions of practice under which good medical care could not possibly be rendered. Medical practice would deteriorate from a highly personalized professional service to an impersonal, regimented service.

American medicine has produced unexcelled medical research by individuals. The enactment of section 11 would lessen the incentive for individual medical research by making it impossible for the results of that research to be utilized to their fullest extent. This result the sponsors of the legislation inferentially apprehend by providing for federal grants to *nonprofit institutions and agencies* to encourage and promote research.

American medicine has been responsible for a state of health of the people unexcelled in any other country. The enactment of section 11 would result in a deterioration of the health of the people, for if medical education suffers, if the quality of medical care available to the people becomes attenuated, if the incentive to individual medical research is removed, the resulting harmful effect on the health of the people will be inescapable.

What Does Section 11 Propose?

Section 11 proposes to amend title IX of the Social Security Act to provide general medical, special medical, laboratory and hospitalization benefits to every person currently insured under the act, to the wives and children of such persons and to certain other groups who may voluntarily bring themselves within the coverage of the act.

To provide these benefits, the Surgeon General of the United States Public Health Service would be authorized to make all necessary arrangements. He would, in effect, become the autocrat of American medicine. Although every physician legally qualified by a state may, if he consents to regimentation, participate in this compulsory health insurance scheme, the Surgeon General may by regulation prescribe the conditions of participation. He too would be authorized to determine what compensation the participating physicians may receive and would have the final say as to the manner in which they will be compensated, whether on the basis of fees for services rendered, on a per capita basis, on a salary basis or on any combination or modification of these bases. He would be authorized to limit the number of insured persons a particular physician may treat. He would be authorized to determine what constitutes the services of a specialist.

Ostensibly to assist the Surgeon General there will be created a National Advisory Medical and Hospital Council to be appointed by the Surgeon General, of which he will himself be chairman. This council will have no authority; it will be

authorized only to "advise." While an insured individual may select, normally, from the list of participating general practitioners the physician to treat him, he will be denied that privilege if the physician's quota of patients, as established by the Surgeon General, is already filled. If he is in need of the services of a specialist, he will have no voice in the selection of that specialist. The Surgeon General may arbitrarily assign an insured person to a particular physician if such person does not make his own selection.

The bill provides that in each area the provision of general medical benefit for all insured persons shall be a "collective responsibility of all qualified general practitioners in the area who have undertaken to furnish such benefit." The significance of this provision is difficult to determine. It may signify that each participating physician will be responsible for the quality of medical service rendered by every other participating physician in that particular area.

The Surgeon General would be authorized to determine what hospitals may participate in the scheme. Hospital benefits will range from $3 to $6 for each day of hospitalization, not in excess of thirty days, as determined by the Surgeon General with the approval of the Social Security Board. The rates will range from $1.50 to $4 for each day of hospitalization over thirty but not exceeding ninety. If the insured is placed in an institution for the care of the "chronic sick" the rate will range from $1.50 to $3 a day. Instead of making such payments to the insured individual, the Surgeon General, subject to the approval of the Social Security Board, may make contracts with participating hospitals for the payment of the reasonable cost of hospital service at rates neither less than the minimum nor more than the maximum rates specified, such payment to be full reimbursement for the cost of essential hospital services, including the use of ward or other least expensive facilities compatible with the proper care of the patient.

Insured persons will also be entitled to certain laboratory and other benefits, the nature and extent of which will be determined by the Surgeon General but which will include chemical, bacteriologic, pathologic, diagnostic and therapeutic x-ray and related laboratory services, physical therapy, special appliances prescribed by physicians, and eye glasses prescribed by a physician or other legally qualified practitioner.

Taxes to Provide Benefits

To finance the provisions of this bill, each included employer will be taxed annually at the rate of 6 per cent of his payroll, excluding all remuneration paid to an employee in excess of $3,000 a year, and each insured employee will be taxed 6 per cent annually of the wages received up to $3,000. Self-employed persons will be required to pay 7 per cent of the market value of their services annually up to $3,000. States and political subdivisions and their employees will be taxed at the rate of 3.5 per cent up to $3,000 if such governmental units voluntarily, by compacts, come within the coverage of the Social Security Act.

Of this total tax a certain amount will be credited to a "Medical Care and Hospitalization Account," an amount estimated as in excess of $3,000,000,000 annually.

Grants-in-Aid

Section 12 of the bill, as previously indicated, provides grants-in-aid as a stimulus for medical education, research and for the prevention of disease and disability, in apparent recognition that the enactment of the bill will require such a stimulus. The Surgeon General of the Public Health Service will determine who will be the recipients of such grants and the specific amounts that will be granted. He will determine too whether a particular project is worthy of stimulation.

The enactment of this bill will destroy the private practice of medicine. It will create a political system of medicine dictated by a federal bureaucracy. It will lower the high health level of the people of the United States. Its enactment should be vigorously opposed.

When a state fails to provide sufficient beds, it is committed to a plan that is wasteful, ineffective, and in the long run costly. Tuberculosis is curtailed but little, if at all, by treating only a small percentage of the patients and leaving many open cases in the community to sow the seed for another crop of victims who in their turn will be needing care. If we admit only the advanced cases to give them terminal care, we leave in the homes the hopeful cases until they in turn need terminal care. Half-way measures will not exterminate tuberculosis. A sanatorium bed should be available for every case of active tuberculosis regardless of the stage of the disease. Treatment that will benefit the patient and also serve to shield others by protecting them from infection is the real objective of case finding. The Modern Attack on T. B., Henry D. Chadwick, M. D. and Alton S. Pope, M. D.

Recent Appointments to the State Board of Public Welfare

W. D. STOVALL

GOVERNOR Walter S. Goodland has made two new appointments to the State Board of Public Welfare, the policy-making board of the Department of Public Welfare. Dr. William D. Stovall, Madison, director of the State Laboratory of Hygiene, was nominated to succeed Mrs. Irma Stoddart, Beaver Dam, for the term ending October 3, 1949, and Dr. George R. Baker, Tomahawk, to succeed Dr. Esther de Weerdt, Beloit, for the duration of the same term. Both appointments are subject to confirmation by the Senate when the legislature reconvenes in Madison on January 12, 1944. Dr. Stovall and Dr. Baker are both members of the State Medical Society of Wisconsin.

Dr. Stovall was born at Longtown, Mississippi. He was graduated with honors with the degree of Bachelor of Science from Mississippi College in 1908 and received his degree in medicine at the Tulane University of Louisiana School of Medicine, New Orleans, in 1912. He interned at St. Vincent's Hospital, Birmingham, and took postgraduate work at the United States Marine Hospital, New Orleans.

In 1914 Dr. Stovall came to Wisconsin as bacteriologist at the State Laboratory of Hygiene, of which he has been the director for many years. He has been secretary, vice-president, president, and a member of the Board of Trustees of the Dane County Medical Society; chairman of the Committee on Health and Public Instruction of the State Medical Society and Speaker of the House of Delegates of the Society in 1931. He has served as chairman of the Committee on Cancer of the Society for over eleven years and has been active in the work of the Women's Field Army. At present, he is state chairman of the American Society for the Control of Cancer and is a member of its national board of directors. At the One Hundred Second Anniversary meeting of the State Medical Society held at Milwaukee in September, 1943, he was elected a delegate to the American Medical Association.

In 1940, Dr. Stovall received the Council Award of the State Medical Society.

Dr. George R. Baker, Tomahawk, is a graduate of Milwaukee Medical College and has practiced medicine in Tomahawk since 1900. For years he has been chief surgeon of the Sacred Heart Hospital at Tomahawk, and for the last twenty years, president of the board of education of the city of Tomahawk.

In World War I, Dr. Baker served as captain in the medical corps of the Army and was severely wounded in the Battle of the Argonne. He was awarded the Purple Heart and the oak leaf cluster for gallantry in action. After his discharge from the Army on August 13, 1919, he served as assistant examiner for the United States Public Health Service for two years, after which he became examiner for the United States Veterans' Bureau, a position which he has held continuously since that time.

In joint practice with Dr. Baker is his only son, Dr. Rowe G. Baker.

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

OFFICERS

Mrs. H. E. Twohig, Fond du Lac, President
Mrs. L. H. Lokvam, Kenosha, President-elect
Mrs. F. A. Douglas, La Crosse, Vice-president
Mrs. H. J. Hansen, Sheboygan Falls, Recording Secretary
Mrs. L. J. Keenan, Fond du Lac, Corresponding Secretary
Mrs. N. A. Hill, Madison, Treasurer
Mrs. R. E. Fitzgerald, Wauwatosa, Parliamentarian

COMMITTEE CHAIRMEN

Archives—
Mrs. J. E. Twohig, Fond du Lac
Finance—
Mrs. C. D. Partridge, Cudahy
Hygeia—
Mrs. A. W. Adamski, Racine
Organization—
Mrs. A. H. Barr, Port Washington
Philanthropic—
Mrs. P. J. Clark, Fond du Lac
Press and Publicity—
Mrs. A. A. Quisling, Madison
Program—
Mrs. H. O. Zurheide, Milwaukee
Public Relations
Mrs. E. P. Bickler, Milwaukee
Legislation (special committee)—
Mrs. C. N. Neupert, Madison
Circulation of Bulletin (special committee)—
Mrs. J. C. Fox, La Crosse
War Participation (special committee)—
Mrs. A. J. McCarey, Green Bay

County Auxiliary Proceedings

Fond du Lac

Outlining a program for the year at a buffet supper on September 30, members of the Woman's Auxiliary to the Fond du Lac County Medical Society voted to stress war activities on the home front, and particularly to aid in the project of recruiting young women for the United States Cadet Nurse Corps.

Mrs. J. S. Huebner, president, was hostess to the group. She was assisted by Mrs. J. P. Connell and Mrs. W. C. Wojta.

Plans for Red Cross work were also discussed and will be announced at a later meeting. A report on the state convention held last month in Milwaukee was given by Mrs. Huebner, and members paid tribute to Mrs. H. E. Twohig, state president, who responded.

Kenosha

When the Woman's Auxiliary to the Kenosha County Medical Society met on October 5 at the home of Mrs. P. E. Pifer, Kenosha, new officers for the year were installed. Mrs. A. M. Rauch, retiring president, presented the gavel to Mrs. C. C. Davin, incoming president. Other officers and committee chairmen are:

President-elect—Mrs. C. G. Richards
Secretary—Mrs. W. C. Kleinpell
Treasurer—Mrs. J. P. Graves

Committee Chairmen

Program—Mrs. A. M. Rauch
Hostess—Mrs. L. H. Lokvam
Public Relations—Mrs. E. F. Andre
Philanthropic—Mrs. C. E. Pechous
Telephone—Mrs. A. J. Randall
Press and Publicity—Mrs. W. H. Lipman
Legislation—Mrs. A. L. Mayfield
Ways and Means—Mrs. Alexander Schlapik
Social—Mrs. G. J. Schwartz
Membership—Mrs. H. L. Schwartz

MRS. L. H. LOKVAM

Mrs. L. H. Lokvam, president-elect of the state Auxiliary, was introduced in her new capacity, and Mrs. E. F. Andre reported on the state meeting held in September.

Dr. C. C. Davin, president of the Kenosha County Medical Society, spoke to the group on "Medical Legislation," tracing the subject in an interesting manner through county, state and national fields. Assisting Mrs. Pifer were Mmes. A. L. Mayfield, Alexander Schlapik, S. F. DeFazio, W. C. Stewart and Theodore Sokow.

La Crosse

The first fall meeting of the La Crosse County Medical Auxiliary was held on Wednesday, October 20, at the home of Mrs. W. E. Bayley, La Crosse. After tea was served, Mrs. Gunnar Gundersen, chairman of the public relations committee, analyzed the Wagner–Murray–Dingell bill, and Mrs. John Newhouse reviewed the book, "Burma Surgeon."

Milwaukee

Ten past-presidents of the Woman's Auxiliary to the Medical Society of Milwaukee County were hostesses at the opening luncheon and fall meeting of the group on October 8 at the City Club. This was the first meeting planned by Mrs. John Dale Owen, new program chairman, and conducted by Mrs. F. R. Janney, new president.

The past-presidents included Mmes. Rock Sleyster, J. G. Taylor, H. J. Heeb, E. J. Carey, R. G. Wash-

burn, H. O. Zurheide, R. E. Fitzgerald, C. D. Partridge, W. M. Jermain and R. D. Champney.

Guest speaker at the meeting was Dr. John F. Lundy, director of the department of anesthesia at the Mayo Clinic, Rochester, who discussed "Painless Childbirth." Mentioning a much needed evaluation of the controversial methods of painless childbirth, he pointed out the need of combating the layman's inaccurate information on caudal anesthesia. He also spoke of his work as President Roosevelt's civilian representative on anesthesia to the Army and Navy.

Sheboygan

Committee chairmen for the year were appointed at a meeting of the Sheboygan County Auxiliary held at the home of Mrs. J. J. Boersma, Sheboygan, on October 5. The new president, Mrs. V. F. Neu, named the following chairmen and co-workers, all of Sheboygan unless otherwise indicated:

Program—Mrs. J. F. Kovacic
Membership—Mmes. W. G. Meier; J. J. Boersma; C. M. Yoran, Plymouth
Public Relations—Mmes. F. A. Nause; A. J. Brickbauer, Plymouth; I. M. Bemis, Adell
Archives—Mrs. G. J. Hildebrand
Publicity—Mrs. W. W. Van Zanten
Telephone—Mmes. P. B. Mason, J. W. McRoberts

In the absence of Mrs. L. F. Pauly, the report of the secretary-treasurer was read by Mrs. Kovacic. Mrs. Brickbauer reported on the state convention which was held in Milwaukee in September.

The program was concluded with a review of the book, "Keep Your Powder Dry," which was given by Mrs. McRoberts. Mrs. W. W. Van Zanten and Mrs. V. F. Neu assisted the hostess, Mrs. Boersma.

Society Proceedings

Brown—Kewaunee—Door

At a dinner and business meeting of the Brown-Kewaunee-Door County Medical Society held at the Beaumont Hotel, Green Bay, on October 21, a film on "Lyo-Vac Normal Human Plasma" was shown by Sharp and Dohme Company. The film, shown in color and sound, gave the story of the early development and recent advances in the field of plasma therapy.

Dane

Dr. Herman W. Wirka, associate professor of orthopedic surgery at the University of Wisconsin Medical School, Madison, spoke on "Some Observations on the Recent Outbreak of Anterior Poliomyelitis" at the monthly meeting of the Dane County Medical Society held at the Madison Club, Madison, on October 12 at 8 p. m.

At the business meeting held at 6 p. m., the following officers were elected:

President—Dr. Harold E. Marsh
President-elect—Dr. H. Kent Tenney
Vice-president—Dr. John E. Gonce
Secretary—Dr. George G. Stebbins
Delegates—Dr. Louis Fauerbach, Dr. Llewellyn R. Cole
Alternate-delegates—Dr. Nels A. Hill, Dr. Michael J. J. Coluccy
District Counsellor—Dr. Clair O. Vingom
A. M. A. Delegate—Dr. William D. Stovall

Douglas

The Douglas County Medical Society was held October 6, at which time the following officers, all of Superior, were elected:

President—Dr. Herbert J. Orchard
Vice-president—Dr. Loran W. Beebe
Secretary—Dr. Milton Finn
Censor—Dr. William H. Schnell
Delegate—Dr. James W. McGill
Alternate-delegate—Dr. Henry A. Sincock
Advisory Committee—Dr. Loran W. Beebe, Dr. Victor E. Ekblad, Dr. James W. McGill, Dr. William H. Schnell

Manitowoc

At a special meeting of the Manitowoc County Medical Society held at the Holy Family Hospital, Manitowoc, on September 28, Dr. Edward R. Krumbiegel, Milwaukee, lectured on the Kenny technic in infantile paralysis. Assisted by a staff of specially trained nurses, Dr. Krumbiegel demonstrated the method on patients.

Marinette—Florence

Members of the Marinette-Florence County Medical Society joined physicians of Menominee County, Michigan, at a dinner meeting September 29 at which Dr. Russell R. De Alvarez-Skinner, field consultant in obstetrics for the Department of Health of the State of Michgan, was the principal speaker.

Outagamie

When the Outagamie County Medical Society held its September meeting at the Riverview Country Club, Appleton, on Friday, September 19, Dr. Carl S. Harper, Madison, discussed "Office Gynecology." A golf tournament was held in the afternoon.

Winnebago

A well attended meeting of the Winnebago County Medical Society was held at the Valley Inn, Neenah, on Thursday, October 7, at 6:30 p. m. Dr. Robert C. Brown, Neenah, who recently was transferred from the Brown–Kewaunee–Door County Medical Society to the Winnebago County Medical Society, presented an illustrated lecture on "Diseases of the Hip Joint."

Dr. George N. Pratt, Menasha, and Dr. Brown were appointed to the program committee to take the places of Dr. William H. Hildebrand and Dr. Paul T. O'Brien, who have received commissions in the Navy. Dr. Hildebrand is now stationed at San Diego, California, and Dr. O'Brien, at Great Lakes, Illinois.

Ninth Councilor District

The fall meeting of the Ninth Councilor District Medical Society was held at the Hotel Wausau, Wausau, on Thursday evening, October 21, beginning with a dinner at 6:30 p. m. After the dinner, Dr. Joseph M. Freeman, Wausau, spoke on "Transfusion Reactions," and Dr. R. Charles Adams, of the Mayo Clinic, Rochester, Minnesota, discussed "Anesthesia in the General Hospital."

Tenth Councilor District

At a meeting of the Tenth Councilor District Medical Society held at the Eau Claire Country Club, Eau Claire, on October 9 at 2 p. m., a group of physicians from the Mayo Clinic, Rochester, Minnesota, made up the list of speakers, which included Drs. David M. Berkman, Wallace E. Herrell, Jacob A. Bargen, Byrl R. Kirklin, and Alfred W. Adson.

News Items and Personals

"The recent series of lectures in South Dakota by Dr. Fernan–Nunez of Marquette university, one of the world's leading authorities on tropical diseases, was a timely innovation and service to the state's medical profession. Credit in generous measure is due Dr. Gilbert Cottam, superintendent of the state board of health, who arranged speaking engagements for Dr. Fernan–Nunez in Sioux Falls, Aberdeen, Huron, Pierre and Rapid City.

"By bringing the authority to the public and to the medical profession, the state health department introduced a new and worthy plan. Dr. Fernan–Nunez reached both professional and lay audiences; in Sioux Falls he addressed a gathering of army and civilian doctors, nurses and public health workers, and spoke along less technical lines, with no less important subject, to a joint meeting of the Kiwanis and Cosmopolitan clubs. At each meeting he made a decidedly favorable impression. To the laymen, in particular, he brought some startling but essential facts concerning the extent of dangerous diseases in the world.

"It has since been learned that just before Dr. Fernan–Nunez left for South Dakota Dr. Ross H. McIntire, surgeon general of the United States Navy, was agreeably surprised when informed of the scheduled tour. As verified by Dr. McIntire's statement, South Dakota is one of the first states to institute a program of enlightening its populace to the future problem of tropical diseases brought back by men in the armed forces. We are warned that these diseases will be carried not only by those returning from foreign duty, but even by men stationed in certain parts of our own country where the diseases are endemic and epidemic.

"Physicians are so busy nowadays that it is increasingly difficult for them to refresh themselves on a subject which has heretofore been relatively unimportant in their practice. Up to now, tropical diseases, such as malaria, have been among our minor concerns. At last they have become a serious threat, and a profession already hard-pressed by war-time conditions must be prepared to deal with it—to prevent its outbreak, if possible, but at all odds to hold its attack in check.

"Significantly, as physicians point out, the chronic stage of the prevalent tropical ailments seem to stimulate almost any of the common illnesses known to man. The high morbidity or sickness rate and the high death rate from malaria alone are astounding figures. The fact that 5,000,000 persons die each year from malaria, among civilized races, cannot be viewed complacently.

"Likewise sobering is the fact that all tropical diseases have been found in epidemic form, and occasionally in individual cases within this area. Neglected at the outset, a tropical disease could afflict not merely a few individuals in South Dakota, but could well spread to the proportions of an epidemic.

"Realization of these possibilities emphasizes the value of a program such as Dr. Cottam, the well remembered Sioux Falls physician, has initiated. South Dakotans should feel proud that their state board of health has evidenced foresight and leadership in this particular field of preventive medicine." —From the Friday, October 1, 1943, issue of *The Daily Argus–Leader*, Sioux Falls, South Dakota.

Dr. Marcos Fernan–Nunez, whose birthplace is Savannah, Georgia, is a graduate of Universidad Central de Espana Facultad de Medicina, Madrid, Spain, the London School of Tropical Medicine, and the University of Paris. From 1919 to 1923 he was medical director of Columbia Syndicate Hospital, Barranquilla, Columbia, South America. In 1924, he

served as tropical disease specialist with the Spanish Army in the Riffian War, the Spanish Morocco. From 1925 to 1927 he held the position of assistant professor, Pathology and Public Health, Vanderbilt University, Nashville, Tennessee. Since 1927, he has been a member of the staff of the Marquette University School of Medicine, Milwaukee, in the capacity of professor of pathology and bacteriology and associate professor of public health.

Dr. Fernan-Nunez is a Fellow of the American Medical Association, the American College of Physicians, and the Royal Society of Tropical Medicine of London, and an Academician of the Royal Spanish Academy of Medicine. The author of numerous articles on tropical medicine which have been published in various medical journals, he has also written a book entitled "Medical Bacteriology and Clinical Parasitology."

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E. J. CAREY, M. D.

The scientific address at the formal opening session of the American Congress of Physical Therapy held Wednesday, September 8, at the Palmer House, Chicago, was delivered by *Dr. Eben J. Carey,* dean of the Marquette University School of Medicine, Milwaukee. Dr. Carey discussed "Physical Therapy in Medical Education."

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On September 17, Acting Governor Goodland appointed *Dr. Erwin R. Schmidt,* Madison, to the Soldiers' Rehabilitation Board to succeed *Colonel William S. Middleton* who is with the armed services of the United States and on leave of absence from the University of Wisconsin. Dr. Schmidt is chief surgeon at the State of Wisconsin General Hospital.

E. R. SCHMIDT

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The Wisconsin Society for Mental Hygiene held its annual meeting at the Pfister Hotel, Milwaukee, on September 29. Following a business session at seven o'clock, the program was open to the public at eight o'clock. Presiding at the meeting was *Dr. Herbert W. Powers,* Milwaukee.

Speakers at the meeting were *Major John A. Grab,* state medical officer, State Headquarters Selective Service, whose topic was "The Community and Selective Service," and Miss Dorothy Paull, who is in charge of the advisory service to men rejected for nervous and mental reasons.

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All officers of the staff of St. Mary's Hospital, Madison, were reelected for the coming year. They include *Dr. James P. Dean,* president, *Dr. Michael J. Coluccy,* vice-president, and *Dr. George J. Maloof,* secretary-treasurer.

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Dr. Thaddeus D. Smith, Neenah, post surgeon, was appointed as chairman of a committee to organize a clinic for immunization against whooping cough at a meeting of the Veterans of Foreign Wars, Nicolet Post 2126, Neenah, on Monday evening, September 27.

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Dr. Joseph V. Herzog, Milwaukee, was on the program of speakers at the Mississippi Valley Medical Meeting held at Quincy, Illinois, on September 29 and 30. The topic of his speech was "Office Procedure Adaptable to Minor Rectal Pathology."

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At a meeting of the Bayfield Parent-Teachers Association held on Monday, September 27, *Dr. Leonard W. Moody* of Pureair Sanatorium, Bayfield, spoke on the topic "Do You Have Tuberculosis?"

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The first annual meeting of the Dr. William Beaumont Memorial Foundation was held Saturday, September 18, at the Second Fort Crawford Building, Prairie du Chien. The meeting was called for the purpose of electing the first set of officers and directors and forming the initial plans of the organization. Prior to the meeting a membership campaign was conducted in Prairie du Chien, and persons becoming members before the meeting automatically became charter members of the Foundation.

The organization of the Foundation was planned and executed by the Crawford County Medical Society and the Prairie du Chien Kiwanis Club. Officers elected were the following:

Mr. M. J. Dyrud, Prairie du Chien—President
Dr. Olaf E. Satter, Prairie du Chien—Vice-president
Dr. Thomas F. Farrell, Prairie du Chien—Treasurer
Mr. J. Alvin Dru'yor, Prairie du Chien—Secretary
Dr. William D. Stovall, Madison—Chairman of the Board of Directors

The purpose of the Foundation as set forth at the meeting is to perpetuate the name and memory of Dr. Beaumont and his memorable experiments in the physiology of digestion and to recognize the noteworthy medical contributions made by other physicians and surgeons in the United States.

An historic atmosphere was lent to the meeting by its being held in the hospital section of the

Second Fort Crawford, built in 1829, in which Dr. Beaumont served as post surgeon under Colonel Zachary Taylor. This building, which is now owned by the city of Prairie du Chien, has been leased as the home of the Foundation. Tentative plans call for the restoration of the building to its original state as it was when Dr. Beaumont was in charge.

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S. E. GAVIN

Dr. Stephen E. Gavin, Fond du Lac, was guest speaker at a meeting of the Chilton Kiwanis Club at the Great Northern Hotel, Chilton, on Wednesday evening, September 22. He discussed the Wagner–Murray Bill.

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"Conserving Our Children's Health in Wartime" was the subject of a talk presented by *Dr. Henry A. Sincock*, Superior, before a meeting of the Pattison Parent-Teacher Association, Superior, Tuesday evening, October 12.

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Dr. Elston L. Belknap, Milwaukee, spoke before members of the Interprofessional Institute of Milwaukee Monday noon, October 11, at the Pfister Hotel. Speaking as the Milwaukee chairman of the United Nations Committee, Dr. Belknap told his audience that war, like disease, can be conquered.

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The October meeting of the Milwaukee Surgical Society was held at the University Club, Milwaukee, on Monday, October 4. The following discussions were presented:

"Recent Experiences With Dicourmarin"—*Dr. Ralph E. Morter*, Milwaukee

"Extrophy of the Bladder"—*Dr. Arthur A. Schaefer*, Milwaukee

"Upper Urinary Tract Problems in Children"—*Dr. N. Warren Bourne*, Milwaukee

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A meeting of the local health officers of Iron County was held on Friday, October 15, at the Iron County Memorial Building. Registration took place between 9:30 and 10 a. m., and a round table conference, at which the problems of local health officers and questions about their powers and duties were discussed, was held between 10 a. m. and noon. At the afternoon meeting, short talks were given by Iron County physicians and by Miss Ellerine Trione, Iron County nurse, *Dr. Milton Trautman*, Madison, supervisor of local health services, and Dr. Frances Kline, deputy state health officer, Rhinelander.

Major General James C. Magee, Washington, D. C., formerly Surgeon General of the United States Army, lectured on "Medical Conditions at the Battlefronts" before the students and faculty members of the Marquette University School of Medicine on Friday, October 8, at 4 p. m. On October 16, at 11 a. m. he spoke on "Tropical Diseases" at a staff meeting of the Wisconsin General Hospital held at the auditorium of the Service Memorial Institutes.

Major General Magee recently returned from a tour of army hospitals in England and North Africa.

BIRTHS

A son to Dr. and Mrs. Clifford F. Broderick, Wauwatosa, on October 3.

A son, William Cole, to Dr. and Mrs. Thomas W. Tormey, Madison, on October 14.

A son, John Nee, to Dr. and Mrs. John G. Waddell, Madison, on October 19.

DEATHS

Dr. Thomas J. Sheehy, 55, Tomah, died Wednesday, October 13, at the Milwaukee Sanitarium at Wauwatosa, where he had been a patient for about a week. About two months ago he was stricken with a nervous ailment. Following treatment at the Mayo Clinic, Rochester, he recovered sufficiently to resume his practice for a short time, but when his condition became worse again, he entered the Milwaukee Sanitarium.

In addition to his activities as a physician, Dr. Sheehy found time to partake in civic affairs. He had been a member of the board of education of the Tomah Public Schools for many years.

A graduate of the Bennett College of Eclectic Medicine and Surgery, Chicago, he served with the Medical Corps during World War I. For several years, he was a member of the State Board of Medical Examiners.

At the time of his death, he was a member of the Monroe County Medical Society, of which he was secretary, the State Medical Society of Wisconsin, and the American Medical Association.

Surviving him are his widow, two daughters, and a son, who is with the armed forces in North Africa.

Dr. Roland E. Schoen, 65, Beaver Dam, who had been in ill health for the last three months, died Saturday morning, October 2, at St. Joseph's Hospital, Beaver Dam.

Born in Mayville, he received his professional education at Rush Medical College, Chicago, from which he was graduated in 1893. After completing his internship, he returned to Mayville and took charge of his father's practice for a period of six months while his father was in Europe. In October of the same year, he established his own practice in

Beaver Dam, where he was a physician and surgeon until the time of his death. For many terms, he was Beaver Dam's city physician.

He assisted in promoting the establishment of the Lutheran Deaconess Hospital, and, when St. Joseph's Hospital was opened, he was its first chief of staff.

He was a member of the Dodge County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

His widow, one son, Dr. Roland F. Schoen, a Beaver Dam physician, and three brothers survive him.

Dr. Dana B. Dana, 56, died suddenly following a heart attack Sunday evening, September 19, at his home in Kewaunee, where he was born and had practiced medicine for over thirty-three years.

He was graduated from Northwestern University Medical College in 1910. During World War I, he served as a lieutenant in the Army Medical Corps at Fort Riley, Kansas. For more than twenty-five years, he was Kewaunee County's public health surgeon, and he also served as Coast Guard physician and as surgeon for the Ann Arbor and Kewaunee Railroad and the Green Bay and Western Railroad.

With his former partner, Captain L. E. Dockry, now of the Navy, he owned and operated the Dana and Dockry Hospital at Kewaunee, which became the Dana and Witcpalek Hospital when Dr. Dana formed a new partnership with Dr. E. W. Witcpalek.

He was a member of the Brown–Kewaunee–Door County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

Survivors include his widow, three sons, all in the armed services of the United States, and three sisters.

Dr. Henry M. Katz, 59, Cedarburg, died Tuesday, September 21, following an operation the previous Saturday.

Born in Milwaukee on September 5, 1884, he was graduated in 1908 from the Wisconsin College of Physicians and Surgeons. After practicing one year in Milwaukee, he established a practice in Cedarburg.

At the time of his death, he was a member of the Washington–Ozaukee County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

His widow and two sons survive him.

Dr. Albert J. Hodgson, 85, Waukesha physician who gained national recognition for his extensive work in the treatment of diabetes and kidney ailments, died at his home Tuesday, October 5, after a long illness.

Dr. Hodgson was born in the Town of Lisbon March 9, 1858. He attended Carroll Academy from 1872 to 1877 and in 1886 was graduated from Rush Medical College, Chicago, with an M. D. degree. In 1916, he was awarded an honorary degree of Doctor of Science by Carroll College.

After specializing for twenty years in the treatment of diabetes and similar diseases, in 1910 he founded the Spa at the White Rock Mineral Spring Company. Until October, 1920, he actively directed this institution, which meanwhile had gained national fame. Because of his contributions in his specialty, he was listed in *Who's Who*.

Dr. Hodgson was a charter member of the Waukesha County Medical Society and, at its organization meeting June 23, 1903, was elected secretary. At the time of his retirement in 1941, he was made a life member of the Waukesha County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association.

He is survived by his widow, a son, and a daughter.

SOCIETY RECORDS

New Members

H. K. Guth, Waupun.
A. R. Powell, Mauston.
John Connell, Fond du Lac.
B. M. Rinehart, Ogema.

Changes in Address

S. K. Wynn, Madison, to 1631 North 47th Street, Milwaukee.

W. J. Urben, Mendota, to 2405 Rugby Row, Madison.

W. E. Bargholtz, Reeseville, to Ashland.

Judson Forman, Madison, to 2222 North Farwell Drive, Milwaukee.

S. G. Schwarz, Humbird, to 411 South Mechanics Street, Berrien Springs, Michigan.

V. G. Springer, Omro, to 106 Park Avenue, Glencoe, Illinois.

C. J. Picard, Superior, to Thermopolis, Wyoming.

R. J. Dancey, Statesan, to Tuberculosis Service, Bellevue Hospital, New York, New York.

L. L. Sanford, Statesan, to Muirdale Sanatorium, Wauwatosa.

PROCUREMENT AND ASSIGNMENT SERVICE QUESTIONNAIRES

The state chairman for the Procurement and Assignment Service for Physicians is extremely anxious that questionnaires recently circulated be returned as soon as possible. An accurate roster of physicians in each county is essential to the work of the Procurement and Assignment Service, and it is essential also to provide complete information to any source relative to the functioning of the medical profession through that agency.

Last Minute News

Federal Funds for Relocation of Physicians

The President has transmitted to the Speaker of the House of Representatives supplemental estimates for the Public Health Service, amounting to $4,427,550. Of this sum, $2,350,000 will be used, it is proposed, for an extended program of malaria control, for the United States' share of a joint Anglo-American venereal disease control program for the protection of troops stationed in the Caribbean area, "and for the supplying by the Public Health Service, on request of State authorities, of needed medical and dental care, either by temporary financial aid or by direct employment of doctors and dentists, in certain critical areas where acute shortages have developed which cannot be met without recourse to emergency measures."

The transmitted estimates, pending in the House Committee on Appropriations, contain the following proviso:

"*Provided,* That the Surgeon General is authorized, on request of a State health department, (1) to assign medical and dental personnel of the Public Health Service to areas found to be in critical need of additional medical and dental services, such services to be furnished the public in accordance with schedules of fees approved by the State health departments and the Surgeon General of the United States, which fees shall be collected by, and used at the direction of, the State departments of health, to defray the expenses thereof incident to the rendition of such medical and dental services, the balances at the end of the fiscal year to be recovered into the Treasury as miscellaneous receipts, and (2) to enter into agreements with private practicing physicians and dentists under which, in consideration of the payment to them of a relocation allowance of not to exceed $250 per month for three months and the actual cost of travel and transportation of the physician or dentist and his family and household effects to the new location, such physician or dentist will agree to move to and engage in the practice of his profession in such area for a period of not less than one year."

Lieutenant Victor S. Falk Awarded Silver Star Medal

Somewhere in the South Pacific—(delayed)—"For service beyond the call of duty." That short line stood out in the *citation* accompanying the Silver Star medal awarded recently to *Lieutenant Victor S. Falk,* Jr., U. S. N., of 1826 Mountain Avenue, Wauwatosa, Wisconsin, a Navy flight surgeon attached to a Marine dive bomber squadron.

But those words don't begin to tell the story of the valor of this young Navy doctor during the early days of the battle for Guadalcanal—a story as packed with heroism as any that has come out of the South Pacific.

For two days and two nights, without sleep and with only a "few bites of food," Lieutenant Falk dodged bursting Jap shells to give first aid to wounded American troops. He carried the wounded to ambulances and drove them to hospitals through sheets of cannon fire. How he escaped with his life in those two days Lieutenant Falk says is "something of a miracle."

Affable, soft-spoken Dr. Falk had just arrived on Guadalcanal. In the first few days he, like others in the squadron, piled up "foxhole time," safe from the terrific Jap shelling and bombing.

That was early in October, just two months after the first Marines had landed.

Then came October 13, the Jap naval force and the historic two-day shelling.

Lieutenant Falk saw five officers of his squadron killed before they could reach foxholes. Wounded were lying everywhere.

He left his foxhole, ran and crawled more than a mile to a hospital, commandeered a makeshift ambulance, and started picking up wounded. He was both doctor and ambulance driver. At the hospital he stopped long enough to administer treatment to the wounded he had brought in.

The second night of the shelling Lieutenant Falk was performing an operation on a wounded Marine when a shell burst not more than fifty feet from the hospital tent, but both he and the patient escaped.

On October 15, the day after the Jap naval force had been routed, Lieutenant Falk, haggard and near exhaustion from the forty-eight hour ordeal, refused to quit work. Late that afternoon he boarded a transport plane loaded with casualties. He volunteered to care for the wounded on the trip to a base hospital.

Henderson Field was under a heavy bombing raid. As the big transport left the runway, shrapnel

ripped its wings. The ship, however, cleared the field safely.

Lieutenant Falk was the only passenger to return on the plane, now loaded with aviation gasoline and bombs. He caught up on his sleep—on a pile of demolition bombs.

Lieutenant Falk made numerous other trips aboard transport planes caring for wounded troops following the shelling. They came after he had worked from twelve to fifteen hours in the hospital.

Recently Lieutenant Falk was relieved of duty here after his squadron had completed its third combat duty tour.

The son of Dr. Victor S. Falk and Mrs. Falk of Wauwatosa, Lieutenant Falk graduated in 1939 from the University of Wisconsin Medical School. Before enlisting in the Navy, he was a resident surgeon at Carle Memorial Hospital, Urbana, Illinois.

Lieutenant Falk won his flight surgeon's wings in 1942, and since that time has served as flight surgeon with Marine dive bomber squadrons.

RECENT WISCONSIN LICENTIATES

The Wisconsin State Board of Medical Examiners, at a meeting held in Milwaukee on June 29, 30 and July 1, licensed the following physicians in the practice of medicine after they had successfully passed an examination:

Name	*School of Graduation*	*Year*	*Present Address*
Beck, John J.	Harvard	1942	Wautoma
Bennett, Maxine	Nebraska	1942	1 South Pinckney Street, Madison
Chess, Stephen J.	Marquette	1942	3550 South 92nd, West Allis
Cook, James C.	Wisconsin	1942	828 College Avenue, Racine
Falsetti, Frank P.	Marquette	1943	Eloise Hospital, Eloise, Michigan
Farrell, John J.	Harvard	1942	329 South Beaumont, Prairie du Chien
Goesl, Andrew G.	Marquette	1942	3375 North 49th, Milwaukee
Litzow, Louis T.	Marquette	1942	1229 South 29th, Milwaukee
Marshall, Helen S.	Wisconsin	1942	1917 University Avenue, Madison
Mateicka, Paul J.	Wisconsin	1942	3058B North 22nd Street, Milwaukee
McIver, Forde A.	South Carolina	1942	Wisconsin General Hospital, Madison
Merline, Gerald B.	Creighton	1942	1339 Cherry Street, Green Bay
Morton, James A.	Michigan	1942	2741 Mason, Madison
O'Donnell, Mae J.	Wisconsin	1941	Milwaukee County General Hospital, Mil.
Pachefsky, S. L.	Marquette	1943	1637 North 19th Street, Milwaukee
Pollard, Wm. H., Jr.	Wisconsin	1942	193 North Randall, Madison
Powell, Adrian R.	Loyola	1942	% Hess Clinic, Mauston
Prouty, Margaret	Nebraska	1942	Jackson Clinic, Madison
Ramirez, Eli A.	Marquette	1943	Milwaukee General Hospital, Milwaukee
Reibold, Frank W.	Marquette	1943	633 Sheldon Street, Madison
Rohde, Elmer P.	Wisconsin	1942	1609 First Street, Merrill
Schroeder, Jack D.	Wisconsin	1942	212 Madison Street, Janesville
Stoops, Charles W.	Wisconsin	1942	126 South Court Street, Platteville
Swan, Franklin D.	Loyola	1942	Minonk, Illinois
Triggs, Perry O.	Wisconsin	1942	Marshfield
Wood, Christine A.	Wisconsin	1942	406 West 5th Street, Marshfield
Zotter, Hugo J.	Marquette	1942	2239A North 35th Street, Milwaukee

The following physicians were granted licenses through reciprocity:

Busby, William, Jr.	Arkansas	1938	904 West Adams, Chicago, Illinois
Coon, William L.	Nebraska	1934	5613 West Michigan Street, Milwaukee
Filip, Hypolit K.	Michigan	1941	3035 West Wisconsin Avenue, Milwaukee
Hanson, Norbert O.	Minnesota	1942	Bloomer, Wisconsin
Jacks, Robert R.	Illinois (Old College of P & S)	1905	Box 53, Racine
Lehner, Robert H.	Rush	1941	Cook County Hospital, Chicago, Illinois
Levitin, Evelyn S.	Rush	1938	Wisconsin General Hospital, Madison
Lindberg, David O. N.	Boston	1915	State Sanatorium, Oakdale, Iowa
McCroskey, Robert C.	Northwestern	1941	2827 South Logan Avenue, Milwaukee
Pennie, Daniel F.	Minnesota	1914	1st & Hammond Avenue, Superior
Peterson, Freddie N.	Northwestern	1940	Childrens Hospital, Milwaukee
Ravitz, Louis A.	Arkansas	1941	4315 West Lisbon Avenue, Milwaukee
Shapiro, Arthur L.	Illinois	1936	4129 North 42nd Street, Milwaukee
Tumminelli, William B.	St. Louis	1934	1300 University Avenue, Madison

The Wisconsin State Board of Medical Examiners, at a meeting held in Milwaukee on September 13 and 14, licensed the following physicians in the practice of medicine by reciprocity:

Alpert, Henry R.	George Washington	1932	2566 North 67th Street, Milwaukee
Berger, Louis M.	Rush	1935	2465 North Sherman, Milwaukee
Dafoe, William A.	Harvard	1940	Boston City Hospital, Boston, Massachusetts

Name	School of Graduation	Year	Present Address
Farisy, Arthur T.	Rush	1920	1241 South 53rd Street, Milwaukee
Fash, James C.	Illinois	1940	5597 Butternut Court, Greendale
Malbin, Morris	Rush	1938	St. Mary's Hospital, Madison
Putnam, L. Irene	Rush	1928	903 East Kilbourn, Milwaukee
Putnam, Mary	Johns Hopkins	1915	State Office Building, Madison

Tuberculosis in Our Industrial Army: An Appeal to Management and Labor

By the Council on Military Affairs and Public Health of The American College of Chest Physicians

THE following extracts are taken from the above article which appeared in the May–June, 1943, *Journal of the American College of Chest Physicians*, Volume IX, No. 3:

"Believing in the importance of the protection of our industrial army against tuberculosis, as well as our fighting army, we have herewith assembled certain facts and statistics with the hope that they will constitute an appeal to both labor and management to the end that all industrial workers will be given the advantage of x-rays."

"It is now unquestioned that an increase in tuberculosis morbidity and mortality will be an inevitable result of war conditions. Overcrowding, limitation of protective foods, limitation of fuel, shortage of hospital beds, the mass entry of women into industry, poor housing conditions, and the general war strain will tend to undo the great progress made during the past several years which has resulted in the lowering of the mortality rate of tuberculosis. . . ."

"Tuberculosis still claims half the total deaths of all causes between the ages of 15 and 24 years. Recent figures show that among our supposedly healthy adolescent population between the ages of 18 and 24, 3 per thousand have unsuspected active tuberculosis, and that more than 1 per thousand is a potential source of infection. This state of affairs is due to the fact that it is only upon the arrival of symptoms, and not always then, that the patient seeks medical advice. . . ."

"Among a group of only 1,050 men and women workers in one small ordnance plant the U. S. Public Health Service found 6 cases of previously unknown minimal tuberculosis; 3 cases of moderately advanced disease, two of which had cavities; and one far advanced case. This indicates that in the fight to conserve industrial manpower tuberculosis is a silent enemy worthy of consideration. Unless steps are taken to retard it, the disease may spread insidiously from the one per cent of workers who harbor it to healthy fellow workers in the factories, and to unsuspecting families at home. . . ."

"An x-ray examination of the chest is now a 'must' for every soldier, sailor, marine, WAAC, WAVE and SPAR. The next most important step is to take the same precaution among our equally essential industrial army.

"As stated above, 'It is only upon the arrival of symptoms, and not always then, that the patient seeks medical advice.' By x-ray examination, we can reverse this condition. The physician can seek out the patient, and not wait until the patient seeks him. . . ."

"By putting every available x-ray machine to work finding tuberculosis, we can prevent many setbacks to our industrial war effort, and to the problems of peace which would necessarily become more complicated by the inevitable increase in the number of tuberculosis casualties."

"Tuberculosis is Preventable and Curable —Put Every X-Ray Machine to Work to Find Tuberculosis."

The imprint from which the above extracts were taken can be had by writing to the Council on Military Affairs and Public Health, American College of Chest Physicians, 500 North Dearborn Street, Chicago, Illinois.

The Press

Shall We Change Our Flag?

"State medicine—political control of medical service—always has meant, always will mean, for the mass of people, medical care through and by physicians who are politically amenable rather than by those with superior abilities and skills. That is the opinion of the medical profession and others who oppose the proposal now pending in Congress to socialize medicine under the label of humanitarianism. The proposal is officially listed as Senate Bill No. 1161. On the surface, it merely provides for the extension of social security legislation. In reality, it is a selfish ruthless scheme to destroy the liberties of every doctor in the nation. Its implications are terrifying to thoughtful citizens who see in it a precedent that can be used to impose virtual serfdom upon any group whose services may next be demanded, for the avowed purpose of furthering the 'general welfare.' If the medical profession can be seized, lock, stock, and barrel by government, what about the industries that clothe, house, feed and transport us? All of them are vital. Even the amusement industry is considered essential to the war effort. Why not write a law, seize the works and call it by the right name—communism?

"If we want immediate comfort and security badly enough to abandon the basic principles of individual freedom that have made this nation what it is, we should quit pretending to be fighting for democracy and freedom. We are not. We are fighting to be merely comfortable. Instead of the stars and stripes, our standard should be a feather bed emblazoned with a plate of food." From the *Colby Phonograph*, September 2, 1943.

Socialized Medicine

"Last week Dr. Stephen E. Gavin of Fond du Lac addressed the Kiwanis club here on the subject of a bill, now before congress, which would place the practice of medicine, including the services of physicians and hospital care, completely at the direction of a government bureau in Washington. The surgeon general of the United States would be in complete charge. He would have at his disposal annually a minimum fund of three billion dollars. He would hire doctors, determine their salaries and the fees they would charge. He would have authority to determine the number of persons for which each doctor would be required to provide medical services. The freedom of the individual to choose his family doctor, to change from one doctor to another as he desired, would be at an end. In fact the entire private practice of medicine as it has been developed in our country would be at an end.

"It is easy to vision what some of the effects of so revolutionary a system would be. Your doctor would be paid by a government bureau. To hold his job, it would be necessary for him to please the bureaucrat who is responsible for his paycheck—not you, his patient. Your choice of a doctor would be limited, if you were left any choice at all. You would be assigned to the care of a certain physician by the government. You would be at the mercy of a government bureau which would necessarily have to write regulations to cover millions of cases and could not possibly make exceptions for the particular attention your case might merit.

"The idea is completely totalitarian. The state would do all things for all men. The state would be supreme, the individual something to be ordered around as the fancy of some bureaucrat dictated.

"The bill is so revolutionary as to be foreign to anything ever experienced in this country. It is not likely to be passed at the present session or even later in its present drastic form. But the point to remember is that the idea of regimentation underlying it has advanced to such a stage of acceptance that a political party has formulated it into a measure which is before congress for consideration. The assumption is that the 'social security' and the 'free services' that the government will provide will win support for the measure. The social security and the free services would, of course, cost billions in taxes, a large part of which would be eaten up in salaries and expenses of the government bureaucrats who would order us around.

"The tendency toward socialization and totalitarianism is present with us. Only the people by their votes can check it. We can save our liberties or trade them off for a mess of government porridge—which, if we do any thinking at all, we can be certain that we must provide." From the *Chilton Times–Journal*, September 30, 1943.

Medical Society Official Charged With Bridery

"A little self-examination, and perhaps housecleaning, on the part of organized medicine might be in order these days.

"The supreme court finding of guilty against the American Medical association for violation of anti-trust statutes started a series of revelations.

"The campaign of organized medicine against medical co-operatives and health insurance brought a poor public reaction. It looked like the medical men were trying to prevent an extension of adequate medical care to the people.

"Mr. Kaiser of ship-building fame came along with a program of co-operative medicine in his shipyards that brought clashes between himself and Dr. Fishbein of the AMA. The public looked on, and generally applauded Mr. Kaiser.

"Then the Ohio branch of the American Medical Association astounded the country with the launch-

ing of a campaign against federal legislation, enacted last spring, providing for medical care for wives of men in the armed services. The Ohio group actually sent out an appeal to physicians in 39 states which have accepted the plan to withdraw from participation. The reactionary medical clique in Pennsylvania blocked the acceptance of the plan in that state.

"And now, to top it off, Monday's newspapers carry the story that the executive secretary of the Michigan State Medical society has been formally charged with attempting to bribe a member of the Michigan legislature to oppose amendments to a bill affecting medicine in that state.

"Leaders in organized medicine seem to have wandered far afield of the Hippocratic oath they took so solemnly when they finished medical school." From the *Madison Capital Times*, September 28, 1943.

The Dollar Sign in Medicine?

"Pending before the present session of congress, which resumes its deliberations this month, is the Wagner–Murray social security bill.

"The Wagner–Murray bill is designed to offer adequate medical care to the American people at minimum costs. It proposes to do this through a system of health insurance operating in accordance to sound insurance practices.

"One would think that medical men, if they are as high minded as their organizations and spokesmen would have us believe, would be all for a plan to raise the nation's health standards and provide better care and treatment to those who fall ill.

"But they are not. Organized medicine is fighting the Wagner–Murray bill with every resource at its command.

"It is nothing new, of course, for organized medicine to oppose every plan to make medical care available to a larger number of people. The American Medical Association attacked with a vengeance every suggestion of co-operative medicine and discriminated against doctors and patients who affiliated themselves with medical co-ops.

"Organized medicine has fought student clinics at universities, public health vaccinations in the schools, and other mild advances to promote the public health.

"Spearhead organization fighting the Wagner–Murray bill is the 'National Physician's Committee for the Extension of Medical Service,' an agency blessed by the house of delegates of the American Medical association. The committee, it is reported, is being financed by the big drug manufacturers and some unnamed 'philanthropists.'

"Avoiding a frontal attack on the purposes of the bill, the committee is representing the measure as a scheme to provide 'free medical care' to the people.

"That contention is false. The bill is an insurance proposal based on risk sharing and its benefits are no more 'free' than those paid out by a private insurance company in case of loss or injury by fire, accident, or death.

"Doctors are not averse to life insurance—they are among the group that carries the heaviest policies. Why are they so violent, then, in their protests against an insurance plan which would give health protection to millions of Americans at a price they can afford to pay?

"The committee mentioned above is using all the old Tory tricks of propaganda in fighting the Wagner–Murray bill. It is circularizing doctors and professional men all over the country with literature declaring:

" 'Doctors of the United States are faced with a real emergency. . . . They can demand a continuation of the practice of medicine under the Christian concept of the sanctity of the human personality—the American way—or they can refuse to be concerned and to refuse to assume their part of the responsibility.'

"To this reactionary group of doctors the 'American way' evidently includes the barring of people in the lower income brackets from proper medical attention and treatment.

"It apparently means the denial of proper hospital facilities for those who cannot pay for same.

"It apparently includes the right to overcharge patients in families where a major sickness means economic and financial disaster.

"The doctor's committee objects to the Wagner–Murray bill, too, because 'the bill, if enacted into law, would provide general medical and special medical care, laboratory tests and hospitalization for approximately 110,000,000 people.'

"What, pray tell, is so wrong about that? Are the doctors against giving this essential protection to so large a group of the American people?

"We are told that doctors upon entering their chosen profession took the Hippocratic oath under which they pledged themselves to minister to the sick, regardless of whether they are rich or poor.

"Has that oath become a mere classroom formality to be forgotten when one goes out into private practice? Has service to mankind in medicine given way to the dollar sign?" From the *Madison Capital Times*, September 7, 1943.

CORRESPONDENCE

October 6, 1943

The State Medical Society of Wisconsin
Madison, Wisconsin
Attention Miss Merriam J. Kelly,
Assistant to Mr. Crownhart
Gentlemen:

Re: . . .

We feel that you are entitled to a word of commendation and an expression of appreciation from us due to your foresightedness and effort.

The purpose of our letter of September 29 was to learn whether or not the above doctor was registered in Wisconsin. We sent similar letters to all of the medical associations in our neighboring states. You were the only one that thought of referring to the American Medical Association and found a . . . listed in Kansas City, Missouri. It has now developed that he is the man we were looking for.

Please accept our thanks for your assistance.

Yours very truly,

(Signed) J. R. SMITH, Comptroller
Northwestern National Bank and Trust Company of Minneapolis.

Dearholt Day

The fourth annual Dearholt Day will come to Milwaukee Monday, November 15, and to Madison on the following day. These medical teaching institutes for medical students are sponsored by the W. A. T. A. in commemoration of Dr. Hoyt E. Dearholt's lifetime of service to tuberculosis education and each year bring to the Marquette University and University of Wisconsin nationally known authorities in the field of tuberculosis and pulmonary disease.

Dr. Leroy U. Gardner, director of Saranac Lake Laboratory, New York, brings to his audience his years of experience both as an educator and as a research scientist in tuberculosis. Dr. Gardner received his M. D. at Yale in 1914, taught as instructor and assistant professor of pathology at Harvard Medical School, and served the Trudeau Foundation as pathologist for eight years. He became director of Saranac Lake Laboratory in 1926 and has been Director of Research since 1936. Dr. Gardner has been a visiting lecturer with the Rochester School of Medicine since 1934 and is a coauthor of "Text Book on Tuberculosis" published in 1927. He is best known, perhaps, for his research in the field of silicosis and other diseases due to inhaled dust.

Dr. John B. Barnwell, associate professor of internal medicine at the University of Michigan, who shares the program with Dr. Gardner, also combines the practical and educational spheres of experience. Dr. Barnwell received his M. D. from the University of Pennsylvania School of Medicine in 1923 and later was a research instructor in the Department of Pediatrics and Laboratory Pharmacy. He was assistant resident at Trudeau Sanatorium, Saranac Lake, New York, and taught at the Trudeau School of Tuberculosis in 1927–'28. Dr. Barnwell was vice-president of the American Trudeau Society in 1939 and is in charge of the tuberculosis unit at the University of Michigan Hospital, Ann Arbor, Michigan.

In Milwaukee, Dr. Gardner and Dr. Barnwell will address the students in the auditorium of the Marquette University School of Medicine in the afternoon. An evening session primarily for practicing physicians will be held before the Milwaukee Academy of Medicine, the members of the American Trudeau Society, and their guests. In Madison, the medical students will hear Drs. Barnwell and Gardner in the Service Memorial Institute in the afternoon. The evening session will meet with the Dane County Medical society, members of the American Trudeau Society, and their guests.

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Trade News

Third Annual Schering Award Competition

The third nation-wide competition for the Schering Award is now open. Three major prizes of a total value of $1,000 will be awarded to undergraduate medical students who submit the best critical dissertations on the subject of "Hormones and Cancer." As in previous years, the judges for the Schering Award will include outstanding American investigators in the fields of endocrinology, medicine and chemistry.

The Schering Award was established by the Schering Corporation in 1941 for the purpose of encouraging a wider interest in current endocrinologic developments among undergraduate medical students. The competition is sponsored and administered by the Association of Internes and Medical Students, and participation is limited to undergraduate medical students in the United States and Canada. All manuscripts must be submitted no later than January 15, 1944. Communications should be addressed to "The Interne," 7 East 42nd Street, New York 17, N. Y.

New Ethicon Eye Sutures Developed by Johnson & Johnson

As a result of several years research, a new and complete line of seventeen eye sutures has just been announcd by the Ethicon Suture Division of Johnson & Johnson.

The new Ethicon Eye Sutures, offered in Plain and Type B Mild Chromic Surgical Gut, as well as Twisted Silk, are distinguished by their unusual flexibility.

All Ethicon Eye Sutures are equipped with Eyeless Atraloc Cutting Point Needles. These needles, made under a Johnson & Johnson patent, are hand-forged and hand-sharpened. All materials in Ethicon Eye Sutures are selected to meet the exacting requirements of the eye surgeon.

Penicillin Production Streamlined

A streamlined process of Penicillin production, resulting from two years' research in the Parke–Davis Laboratories, promises to cut down substantially the production time required, according to Homer C. Fritsch, General Manager of the Company.

"The present method of producing Penicillin requires from 6½ to 14 days," he said in an interview recently. "We have advanced our methods to where we can produce in 2½ to 3 days without using cumbersome equipment."

This constitutes a significant forward step, since the bottle-neck in the Penicillin situation, to date, has been the fact that the drug has been available only in comparatively small amounts. Parke, Davis & Company is now regularly supplying Penicillin to the government and has recently expanded its facilities for producing the new "miracle" drug.

The Mead Johnson Vitamin B Complex Award

Nominations are solicited for the 1944 award of $1,000 established by Mead Johnson and Company to promote researches dealing with the B complex vitamins. The recipient of this award will be chosen by a committee of judges of the American Institute of Nutrition. The award will be given to the laboratory (nonclinical) or clinical research worker in the United States or Canada who, in the opinion of the judges, has published during the previous calendar year (January 1 to December 31) the most meritorious scientific report dealing with the field of the B complex vitamins. While the award will be given primarily for publication of specific papers, the judges are given considerable latitude in the exercise of their function. If in their judgment circumstances and justice so dictate, it may be recommended that the prize be divided between two or more persons. It may also be recommended that the award be made to a worker for valuable contributions over an extended period but not necessarily representative of a given year. Membership in the American Institute of Nutrition is not a requisite of eligibility for the award.

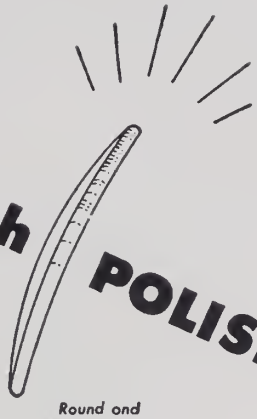
To be considered by the committee of judges, nominations for this award for work published in 1943 must be received by the secretary, Arthur H. Smith, Ph. D., Wayne University College of Medicine, Detroit, by Jan. 10, 1944. The nominations should be accompanied by such data relative to the nominee and his research as will facilitate the task of the committee of judges in its consideration of the nomination.

Dr. da Fonseca, Jr., Brazil, on Lecture Tour

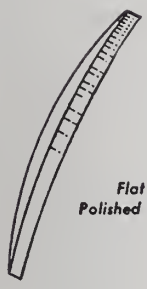
At the invitation of the Pan American Sanitary Bureau, Dr. Olympio da Fonseca, Jr., medical director for Brazil of E. R. Squibb and Sons Inter-American Corporation, has arrived in the United States for an extensive lecture tour. He is appearing before the faculties and students of medical schools throughout this country, discussing *Tropical Medicine* with special emphasis on malaria, African sleeping sickness, amebic dysentery and ring worm infection.

Dr. da Fonseca is a professor at the National School of Medicine of the University of Brazil and is connected with the Medical Centre of Ceara and the Department of Health of that state. He has attained world-wide renown as a mycologist, both as teacher and as director in this field at the In-

The finishing touch POLISHED EDGES



Round and Polished Edge



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stitute of Manguinhos. He is the author of the textbook, "Medical Parasitology."

Dr. da Fonseca will lecture at the University of Wisconsin Medical School on November 17.

Companies Combine to Form Wyeth, Incorporated

The formation of Wyeth, Incorporated, as one of the nation's largest ethical drug houses through the grouping of seven companies now operating in the pharmaceutical, biological and nutritional fields, was announced today by American Home Products Corporation, of which the new company will be a wholly-owned subsidiary.

The companies which will comprise Wyeth, Incorporated, include some of the oldest and most important units in the ethical drug industry. They are John Wyeth and Brother, Incorporated, of Philadelphia, 83-year-old manufacturer of pharmaceuticals; S. M. A. Corporation of Chicago, Illinois, and Mason, Michigan, producers of products for infant nutrition; the Reichel Laboratories, Inc., of Kimberton and West Chester, Pennsylvania, one of the largest producers of blood plasma for the Armed Forces and manufacturer of biologicals, the Bartos system of allergenic protein diagnostics and a pioneer in the development of the new wonder drug, penicillin; Gilliland Laboratories, Inc., of Marietta, Pa., manufacturers of a comprehensive line of biologicals; Petrogalar Laboratories, Inc., of Chicago, makers of Petrogalar; General Biochemicals, Inc., of Chagrin Falls, Ohio, manufacturers of vitamins, and The Bovinine Company of Chicago, products for anemia.

The combination of these companies to function as one big ethical drug house climaxes the steady expansion of American Home Products Corporation in the ethical drug field. All seven companies are at present subsidiaries of American Home Products, two of them having been acquired over the past year.

Dr. Charles F. McKhann Joins Parke, Davis and Company

Dr. Charles F. McKhann, who has for several years been on the faculty of the University of Michigan, has resigned from that institution to accept a position as Assistant to the President of Parke, Davis and Company. Dr. McKhann will devote his time entirely to the scientific activities of the company. He will assume his new duties October 15.

Forecast of Increase in Penicillin Production

A forecast that "under the powerful impetus of government agencies" there should be sufficient penicillin produced to provide more nearly for civilian as well as military needs within the next twelve months was issued today by Dr. Theodore G. Klumpp, president of the Winthrop Chemical Company, Inc. Dr. Klumpp is a member of the Penicillin Producers' Advisory Committee that met recently in Washington with the Office of Scientific Research and Development and the WPB.

For the immediate present, public health authorities should absorb all possible knowledge on penicillin as a means of "completing the link between producers, the government and the public," Dr. Klumpp stated. He called attention to the forthcoming Wartime Public Health Conference and 72nd annual meeting of the American Public Health Association to be held at the Pennsylvania Hotel, New York, Oct. 11–14, at which, he said, the new "miracle drug" would evoke "major interest."

NEW JOURNAL SHEDS LIGHT ON SOVIET MEDICINE

The first number of the *American Review of Soviet Medicine*, which was scheduled to appear on October 25, features papers by Dr. E. I. Smirnov, executive director of the Red Army Medical Corps, and Dr. Nikolai N. Burdenko, chief surgeon of the Red Army. Dr. Smirnov's paper reveals for the first time the prewar plans made for the care and hospitalization of the wounded, their shortcomings under actual battle conditions, and their subsequent drastic revision to meet the exigencies of mobile defense and attack. Dr. Burdenko, who has recently been granted honorary membership in the International College of Surgeons, discusses the effects of frostbite on the nervous system.

Sharply contrasting points of view on restorative surgery of peripheral nerve lesions are presented by Dr. Vladimir V. Lebedenko and Dr. N. I. Propper-Grashchenkov. Dr. Lebedenko disputes the prevailing view that three months must elapse after injury before restorative surgery may be undertaken while Dr. Propper-Grashchenkov holds that the long time-lag is essential and that defects may be remedied by nerve transplantation.

Dr. Spasokukotski's revolutionary method of feeding during operations on penetrating abdominal wounds is described in a paper by Dr. V. A. Panikov. The method consists of introducing a mixture of eggs, milk, distilled alcohol, and other foods into the abdomen during surgical intervention and is said to have produced remarkable results.

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THE JOURNAL BOOKSHELF

BOOK REVIEWS

Any scientific publication reviewed in this column may be obtained for inspection. Orders for such inspection should be directed to the Medical Library Service, S. M. I. Building, Madison, Wis.

Indigestion. Its Diagnosis and Management. By Martin E. Rehfuss, M. D. professor of clinical medicine; and Sutherland M. Prevost, lecturer in therapeutics, Jefferson Medical College, Philadelphia. Cloth. Price, $7. Pp. 556, with 63 illustrations. Philadelphia: W. B. Saunders Company, 1943.

In the entire medical science, no phase of healing is more vital to the peace, happiness, and success of mankind than the cure of indigestion. A stomach that functions improperly and painfully undermines the working efficiency of the body and spirit. It is proper, therefore, that a treatise on indigestion should be directed primarily to the general practitioner. However, when the book is written by one who has been in the active practice of gastroenterology for almost three decades, the attention of the internist and gastroenterologist must likewise be enlisted. The successful treatment of indigestion entails not only a scientific approach to the diverse problems presented but also much of the art of medicine. Martin E. Rehfuss, by long experience and extensive research, is uniquely qualified to aid both the general practitioner and the specialist with their gastric problems. It is propitious likewise that his book should appear at this time, for he has lived through that era which has nurtured gastroenterology from its infancy to adulthood.

Chapters on history taking and the physical examination of the patient ordinarily would be of interest only to the undergraduate student, but not so in this instance. These chapters are painstakingly written and illustrated with many excellent drawings to help the reader localize the probable region of pathology or the source of symptoms. There is no other branch of medicine where history taking plays so important a part both in diagnosis and in treatment.

The author next discusses the various diagnostic technics of precision, which include the analysis of gastric and duodenal contents, roentgenography, gastroscopy, and gastrophotography. The chapter devoted to the analysis of the contents of the stomach and duodenum is especially interesting because of the author's contributions in this field. He emphasizes the great amount of information that

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can be obtained by an adequate study of the gastric and duodenal contents. The information that can be obtained is presented in detail, as well as the technics required for satisfactory study. Here again, diagrams play an important part.

The chapter on roentgenography is adequately illustrated, not only with drawings but also with plates of roentgen films. Only in exceptional circumstances would it be necessary for one to refer to writings devoted exclusively to the roentgenologic study of the gastrointestinal tract.

The chapter on gastroscopy and gastrophotography is brief, as it should be, for these are two highly refined technics. In the opinion of the reviewer, the place of gastroscopy probably belongs somewhere between the very conservative appraisal of the author on the one hand and the enthusiasm of Schindler, the dean of gastroscopists, on the other hand. It seems probable that in the future gastroscopy will assume a greater place of importance than that which it now has in its infancy. On the other hand, gastrophotography, as it is now employed, would seem to have a very limited place. This chapter serves to acquaint the reader with these technics without an attempt to instruct one in their use.

Succeeding chapters are devoted to the various types of indigestion, including nervous indigestion, indigestion due to allergy secondary to infection, and functional gastric disturbance. Of help to the clinician is the inclusion of a number of prescriptions in the chapter on nervous indigestion. The chapter on allergy includes a number of tables handy for ready reference in an effort to run down possible allergic food factors as a cause of symptoms. Separate chapters then are devoted to the following: the inflammatory conditions of the stomach, gastritis and ulcer; on gastric malignancy; biliary indigestion; and cardiovascular indigestion due to cardiovascular disease, that due to reflex disturbances, that occurring during old age, and that occurring during the menopause. There is even a chapter on gastric disease in wartime. The division of these various subjects into separate chapters helps to make the information readily available.

The chapter on vitamins is brief, as it must necessarily be even though it is absolutely essential. The information is all of a practical nature and is adequate for most clinical needs.

The great importance of water in nutrition, all too frequently ignored, is emphasized in a brief chapter by itself.

The final several chapters of the book concern themselves with indigestion and diet, dietary indications in disease, calories, materials of diet, diet in disease, and dietary treatment. There are tables on the composition of food and the caloric values of various foods and suggested menus for various diseases. These tables are numerous and contribute greatly to the value of the book.

Throughout the entire book there is the painstaking, meticulous analysis of the seasoned clin-

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ician which should make anyone, be he general practitioner, nutritionist, internist, gastroenterologist, or even surgeon, desirous of having this book at his elbow where he can refer to it at any time. K. L. P.

Fundamentals of Immunology. By William C. Boyd, Ph. D., associate professor of biochemistry, Boston University, School of Medicine; associate member, Evans Memorial, Massachusetts Memorial Hospitals, Boston. Cloth. Price, $5.50. Pp. 446, with 45 illustrations. New York: Interscience Publishers, Inc., 1943.

"Fundamentals of Immunology" gives a presentation of antigens, antibodies, complement, and the serologic reactions in keeping with the recent advances in immunochemistry. The bibliography and the varied laboratory and clinical technics presented provide for the assignment of collaterial reading and laboratory exercises in a well rounded course. While the desirability of emphasizing basic principles must be granted, it is still true that the student generally needs considerable help in acquiring a sustained view of the operation of those principles in vivo. For this reason the reviewer would find the book improved by a more thorough consideration of the mechanisms of resistance, by discussions of phagocytosis and of antibacterial and antitoxic immunity commensurate with those given to anaphylaxis, allergy, and antivirus immunity.

"Fundamentals of Immunology" is an excellent and timely textbook written by a significant contributor to the field. It should insure the competent reader a clear picture of current knowledge and practice in the field of immunology. F. E. H.

Flying Men and Medicine. The Effects of Flying upon the Human Body. By E. Osmun Barr, M. D., aviator surgeon and author. Cloth. Price, $2.50. Pp. 254, illustrated. New York: Funk & Wagnalls Company, 1943.

This book describes the effects of flying upon the various body functions. It explains how these physiologic effects of aviation determine the physical requirements for pilots and other personnel of the air force. The physiology presented in the book is correct and is related in simple, nontechnical language and in a very fascinating style. R. C. H.

The Principles and Practice of War Surgery. With Reference to the Biological Method of the Treatment of War Wounds and Fractures. By J. Trueta, M. D., formerly director of surgery, General Hospital of Catalonia, University of Barcelona; assistant surgeon (E. M. S.) Wingfield-Morris Orthopaedic Hospital, Oxford; acting surgeon-in-charge, Accident Service, Radcliffe Infirmary, Oxford. Cloth. Price, $6.50. Pp. 441, with 144 illustrations. St. Louis: The C. V. Mosby Company, 1943.

This is an excellent monograph dealing with the revised Orr treatment. It is done with fine attention to detail. Orthopedic men will be particularly interested, but during war time it is of value to all surgeons. I recommend it highly as a very complete and compact book. J. L. N.

Chemotherapy of Gonococcic Infections. By Russell D. Herrold, B. S., M. D., associate professor of surgery (urology), College of Medicine, University of Illinois. Cloth. Price, $3. Pp. 137. St. Louis: The C. V. Mosby Company, 1943.

In these days of effective chemotherapeutics, most physicians see few cases of acute gonococcic infection. Hence, it is valuable to have available the experiences of one who has had an opportunity to treat large numbers of such cases with the newer compounds. The present volume is an excellent successor to the presulfonamide workers on the same subject.

Dr. Herrold's discussion is complete and contains the best of modern thought and practice on the subject. Particularly to be commended is the discussion of those trying cases which are refractory to sulfonamide therapy and the clear exposition of the problems of differential diagnosis. P. M. C.

The Therapy of the Neuroses and Psychoses. A Socio-Psycho-Biologic Analysis and Resynthesis. By Samuel Henry Kraines, M. D., associate in psychiatry, University of Illinois College of Medicine; assistant state alienist, State of Illinois; diplomate of American Board of Psychiatry and Neurology; captain, United States Army Medical Corps, Ed. 2. Cloth. Price, $5.50. Octavo, pp. 567. Philadelphia: Lea & Febiger, 1943.

The appearance of the second edition of Kraine's work two years after the first speaks for its usefulness and general acceptance. This was really the first text in psychosomatic medicine more or less disguised by its title. The twenty chapters of this 567 page book are largely devoted to therapy, which is so neglected in the usual text book of psychiatry.

The author goes into elaborate detail in the development of therapy and so presents his material that psychologic mechanisms and analysis of personality are presented at the same time. The volume is a complete text in psychiatry with the emphasis on psychobiology. This expanded edition includes generous discussion of every form of therapy except psychoanalysis, to which he devotes a few pages in explanatory material; detailed interpretation of symptoms, both psychologic and somatic; description of psychoses, constitutional and organic; the psychopathic states; and a chapter on war psychiatry.

The book represents an earnest personal effort to help the mentally sick and a desire to stimulate others in the same effort. It is commended to every physician, to "the general practitioner," and the "nonpsychiatric specialist," for whom it was really written; for in his preface to the first edition, Kraines has said that "every person who understands human actions, and attempts to correct or modify them, is to a greater or less degree a psychiatrist." M. G. M.

Allergy, Anaphylaxis and Immunotherapy. Basic Principles and Practice. A treatise presenting the use of antisera, vaccines, toxoids, blood transfusions, blood substitutes and sulfonamides, in the prevention and treatment of infectious diseases and of the allergic phenomena resulting from their use. By

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Bret Ratner, M. D., clinical professor of pediatrics, New York University College of Medicine; visiting pediatrician and director of pediatrics, Sea View Hospital; associate attending, Children's Medical Service, Bellevue Hospital; consultant pediatrician, French Hospital. Cloth. Price, $8.50. Pp. 834, with illustrations. Baltimore: The Williams & Wilkins Company, 1943.

At a time when such a large number of individuals are being subjected to various immunologic procedures, as well as the use of blood, blood plasma, and the sulfanilamide drugs, a volume which presents the present day theories of the normal and allergic mechanisms involved is very timely. One should have a fair current knowledge of immunity and bacteriology to attain the most information from this book.

The author discusses the immunologic principles involved in the use of whole blood, blood plasma, and other blood substitutes. In his section on the use of the sulfanilamide drugs, he points out the similarity of serum sickness and sulfanilamide reactions with regard to time of occurrence and type of reactions. Immunotherapy in the common infectious diseases is discussed at length, together with allergic reactions which have been observed by the author and others. This section should be especially valuable to the practicing physician who has had perhaps only moderate experience with various immunologic procedures.

There is a considerable discussion devoted to serum sickness in all its aspects. The physiologic pathology of anaphylaxis in various animals and in man and the allergic phenomena are presented. The author favors the theory of arteriolar spasm as the physiologic pathology of allergy in wheal formation and Arthus's phenomenon. However, the riddle of allergy is still not solved. H. P. D.

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New and Nonofficial Remedies, 1943, containing descriptions of the articles which stand accepted by the Council on Pharmacy and Chemistry of the American Medical Association on Jan. 1, 1943. Cloth. Price, $1.50. Pp. 772. Chicago: American Medical Association, 1943.

The current volume of "New and Nonofficial Remedies" continues, with minor improvements, the convenient and informative system of classification adopted for the 1942 volume. The terminology of the official drugs has been revised to conform to the U. S. P. XII and the N. F. VII. One notes that the valuable bibliographic index now appears on white instead of "India Tint" paper, a wartime necessity no doubt. This index appears before the general index, which is now more properly placed at the end of the book. To one accustomed to the old format of "New and Nonofficial Remedies" the new arrangement appears at first somewhat awkward, but with a little use the wisdom and convenience of the changes becomes more and more apparent.

Textual changes and revisions do not appear to be as numerous as in some previous editions. The chapter, Digitalis and Digitalis-like Principles and Preparations, has been extensively and somewhat radically revised to keep pace with the changing attitude toward this drug. It is understood that in this revision the Council had the aid of the foremost digitalis authorities, pharmacologists and clinicians alike. Other revisions have been made obviously to keep the book up to date with medical knowledge. To cite a specific revision indicating the increasing skepticism of the Council concerning a drug, it is interesting to contrast the following sentence in the 1942 general article on Chaulmoogra Derivatives, "The therapeutic properties of chaulmoogra oil appear to be due to these optically active

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unsaturated fatty acids of the chaulmoogric series," which in the 1943 edition reads "Any therapeutic properties chaulmoogra oil may possess would appear to be due to these optically active unsaturated fatty acids of the chaulmoogric series."

No such spectacular new additions as the appearance in a previous volume of the sulfonamides is to be noted. Among the more noteworthy of the new additions are Nikethamide, the central nervous stimulant which was first introduced as coramine; diethylstilbestrol, the synthetic estrogen; Trichinella extract for the diagnosis of trichinosis; and zephiran chloride, a mixture of alkyl dimethyl benzyl ammonium chlorides, an interesting new anti-infective agent.

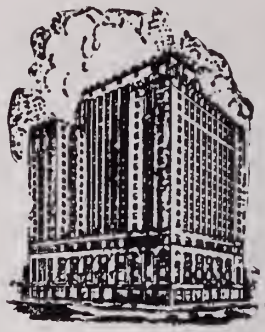
No one can examine the successive volumes of "New and Nonofficial Remedies" without increasing his profound respect for the faithful and unselfish work of the Council on Pharmacy and Chemistry in the cause of rational therapeutics. Each volume represents a progressive milestone on the road of medical science.

Reports of the Council on Pharmacy and Chemistry. Issued under the direction and supervision of the Council on Pharmacy and Chemistry of the American Medical Association. Cloth. Price, $1. Pp. 207. Chicago: American Medical Association, 1943.

Through the years the size of this volume has grown with the increased work of the Council on Pharmacy and Chemistry until the present edition has the same number of pages as the book published in 1908, which covered the Council's first four years of activity. Some of the functions of this group are well known, but a more thorough understanding of the Council's scope may be gained from the annual reprint.

This volume epitomizes that phase of the Council's work which may be said to be collateral to the "acceptance" of drugs, the informative consideration of current medical problems in the interest of rational therapeutics. It contains reports of studies by private investigators which were originally published in *The Journal of the American Medical Association* under the sponsorship of the Council, such as preliminary discussions of new developments in therapeutics and timely articles on the status of recognized agents as well as reports of the omission or rejection of products from "New and Nonofficial Remedies." It also offers a record of current decisions on matters of Council policy.

Several of the reports are of particular interest for various branches of medical science: the use of bulk ether in anesthesia, the absorption of surgical gut (catgut), the higher types of antipneumococcic rabbit serum, the surgical and medical treatment of animals with experimental hypertension, and the status of racemic epinephrine solutions for oral administration. The reports in this small compact volume represent expert medical consensus and are proffered to aid in the consideration of the value of therapeutic agents.



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Brucellosis in Man and Animals. By I. Forest Huddleson, D. V. M., M. S., Ph. D., research professor in bacteriology, Michigan State College. Revised edition. Cloth. Price, $3.50. Pp. 379, illustrated. New York: The Commonwealth Fund, 1943.

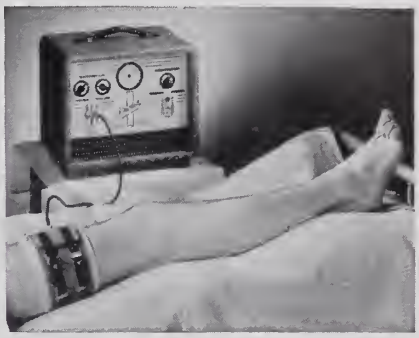
The second edition of this well appreciated monograph on brucellosis brings factual matter with reference to this protean disease up to date with a richer bibliography and especial emphasis on changes in laboratory methods of diagnosis. The historic presentation is excellent, the clinical picture and epidemiology sharply drawn, and the limitations of our methods and knowledge clearly depicted. This book will be of service to all interested in this important disease. P. F. C.

A Manual of Cardiology. By Thomas J. Dry, M. A., M. B., Ch. B., M. S. in Medicine; assistant professor of medicine, University of Minnesota (Mayo Foundation); consultant in Section on Cardiology, Mayo Clinic. Cloth. Price $3. Pp. 310, with 80 illustrations. Philadelphia: W. B. Saunders Company, 1943.

This pocket-sized volume of 310 pages contains in simplified form the essentials of the subject of heart disease in its more common aspects. Much of the material is presented in outline form to insure brevity and conciseness. Controversial subjects have been largely avoided and the subject matter is presented in a more or less dogmatic fashion as is essential in a manual of this type. In general, the illustrations are excellent.

The author was called into the service about the time the book went to press, which may explain some of the gross errors which might otherwise have been picked up by careful proof-reading. For example, the electrocardiogram in fig. 68 on page 227 is completely reversed.

There are several statements made by the author which could be challenged. For example, on page 18 the pulmonic arch is referred to as the pulmonary conus. As has been shown by Susman and others employing angiocardiography, the pulmonary conus never reaches the left border of the cardiovascular shadow but always remains buried in the substance of the heart. On page 46, the typical murmur of mitral stenosis is described as an early diastolic murmur which starts with the second heart sound and fades out. This is contrary to most authorities, who describe the murmur as starting in mid-diastole and, if auricular fibrillation is not present, as frequently merging with a presystolic crescendo murmur. On page 96, the author states, "Enlargement of the left auricle is especially well demonstrated in the left oblique position with a barium filled esophagus." This is probably a misprint and should read "right oblique position." On two different occasions the author refers to the verrucous vegetations of subacute bacterial endocarditis. Most pathologists use this term in describing the valvular lesions of rheumatic endocarditis.



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The danger of epinephrine in the production of serious and sometimes fatal arrhythmias during anesthesia is deserving of emphasis. The author is to be highly commended for recommending coronary dilators of the xanthine group, particularly aminophylline and theobromine, in the face of the negative but poorly substantiated reports to the contrary which have appeared in some of the medical literature recently. The chapter on the treatment of cardiac decompensation is excellent and contains one particularly valuable point. The author recommends discontinuing the severe fluid restriction which has been practiced in the past, permitting the patient as much water as his system calls for. The newer concept of the production of diuresis, particularly with the potassium salts in adequate dosage, is of distinct practical value. In the opinion of the reviewer the author might well have stressed further the value of oxygen in the treatment of decompensation.

In general, the subject of heart disease is adequately covered in a very concise manner. The subject matter is complete and up-to-date, and the text is well illustrated. Except for a few spots which give the impression that the author was hurried and working under pressure, this manual is well done and can be recommended to the medical student, house officer, and general practitioner. C. M. K.

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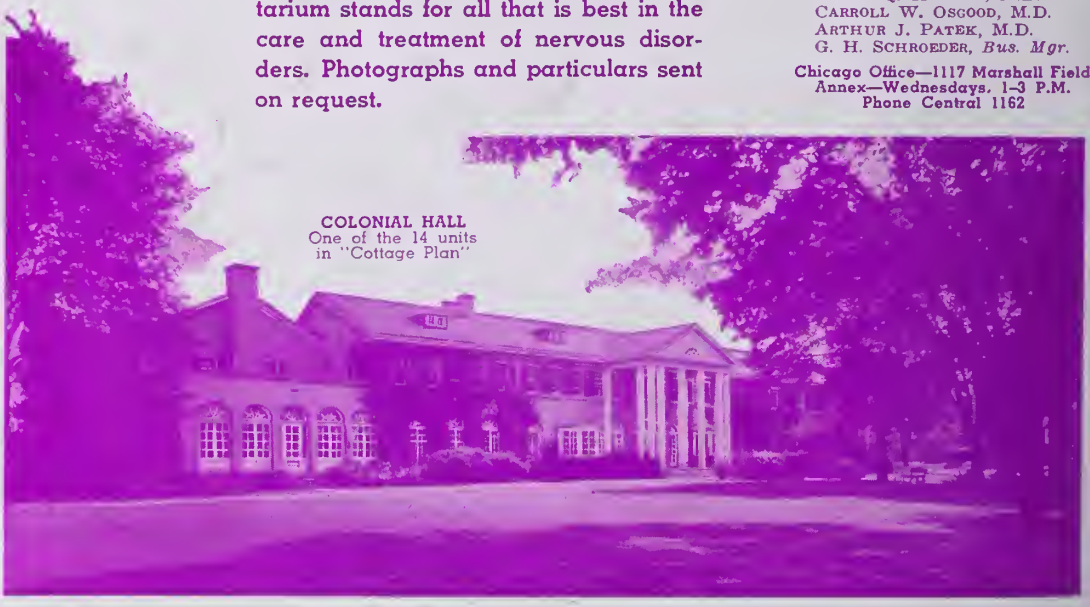

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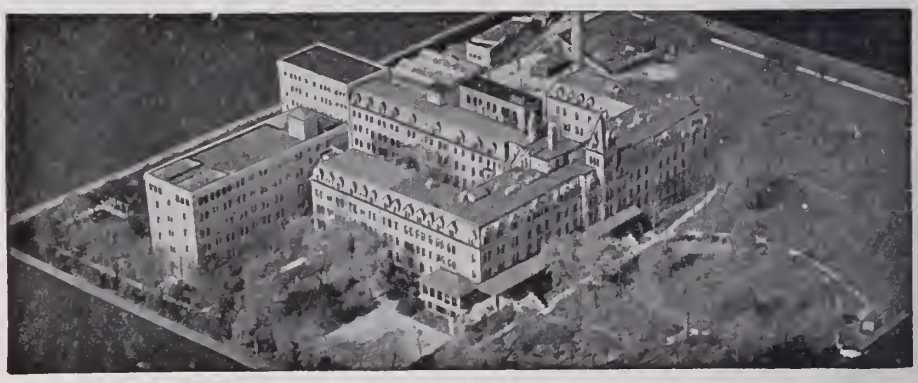

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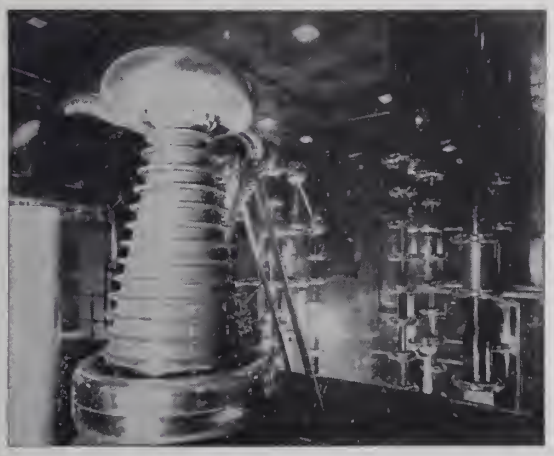

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REFERENCES:

[1]BACKMAN, A. L.: Am. J. Dis. Child. 52:633 (Sept.) 1936.
[2]DIAMOND, L. K.: J. Pediat. 13:143 (July) 1938.
[3]SMITH, C. H.: New York Acad. Med. 15:525 (Aug.) 1940.
[4]FABER, H. K.: Am. J. Dis. Child. 36:1121 (Dec.) 1928.
[5]HUENEKENS, E. J.: J. Pediat. 9:427 (Oct.) 1936.
[6]DWYER, H. L., and NEFF, J. C.: South. M. J. 33:246 (Mar.) 1940.
[7]SHARPE, J. C.: Nebraska M. J. 21:427 (Nov.) 1936.
[8]CAFARATO, T. M.: Ginecologia 4:101 (Feb.) 1938.
[9]SODEMAN, W. A.: Am. J. M. Sc. 200:117 (July) 1940.
[10]SCHOTTMULLER: Deutsche med. Wchnschr. 58-1356 (Aug. 26) 1932.
[11]VAN DER SCHEER, A.: Nederl. Tijdschr. v. geneesk. 77:163 (Jan. 14) 1933.
[12]MILLER, D. K., and BARKER, W. H.: Arch. Int. Med. 60:385 (Sept.) 1937.
[13]BARKER, W. H., and RHOADS, C. P.: Am. J. M. Sc. 194:804 (Dec.) 1937.
[14]RODRIQUEZ MOLINA, R.: Bol. Asoc. med. de Puerto Rico 32:187 (June) 1940.
[15]SUAREZ, R. M.: Am. Int. Med. 12:529 (Oct.) 1938.
[16]GOLDHAMER, S. M.: Arch. Int. Med. 53-54 (Jan.) 1934.
[17]ANNIS, J. W., and COMFORT, M. W.: Proc. Staff. Meet., Mayo Clin. 13:435 (July 13) 1938.
[18]WILSON, R.: Canad. M. A. J. 40:268 (Mar.) 1939.
[19]MEERSSEMAN, F.: Bull. et mem. Soc. med. d. hop. de Paris 55:951 (1939).
[20]FORBES, J. C.: NEALE, R. C., and SCHERER, J. H.: J. Pharmacol. & Exper. Therap. 58:402 (Dec.) 1936.

Literature on request.

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[1] Wilkinson, F. A. H.: Anesthesiology, July 1942
[2] Stein, J. J.: Am. J. Dig. Dis., June 1942
[3] Rapoport, B.: Anesthesia and Analgesia, May–June 1940

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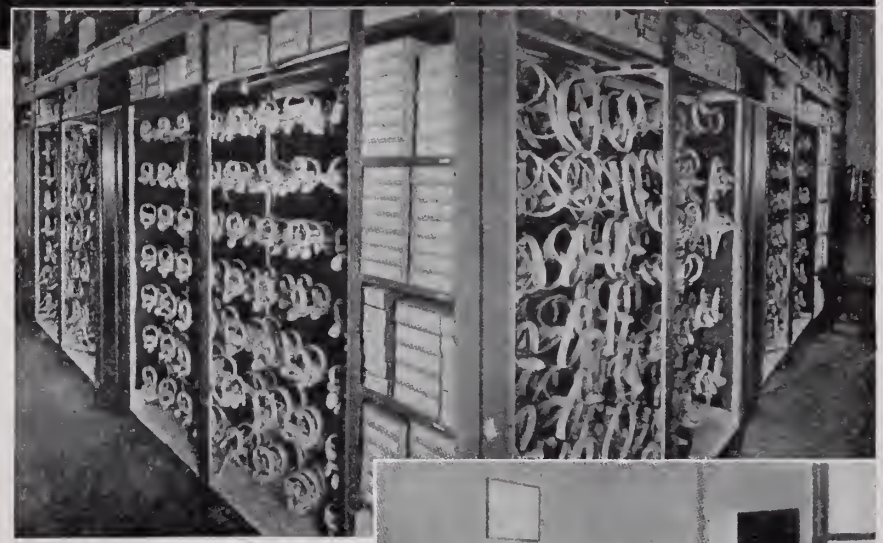

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Some Clinical Aspects of Bronchiogenic Carcinoma

By GEORGE C. OWEN, M. D.
Oshkosh

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Dr. Owen received his M. D. degree from Harvard Medical School in 1931, and has been certified by the American Board of Internal Medicine. Before entering the armed forces, he practiced at Oshkosh. He is a major in the Medical Corps of the Army of the U. S. and is stationed at Fitzsimons General Hospital, Denver.

NOT very many years ago primary carcinoma of the bronchus was an extremely rare disease for which there was no adequate treatment. Now it is seen commonly both by the clinician and the pathologist. Jaffé[1] found cancer primary in the bronchus only less frequently than in the stomach and intestine. Koletsky[2] recently reported that the bronchus was the site of *9.4 per cent* of all cancers and that it ranked second only to the stomach as a primary site in his series of autopsies. While these figures may not represent the true incidence of the disease, they do point very graphically to its frequency. Carcinoma of the stomach or of the large bowel is commonly seen and is kept constantly in mind by the practicing physician. We do not have carcinoma of the bronchus constantly in mind, and that is perhaps one reason why the diagnosis is not made more frequently.

Early Diagnosis

That the diagnosis should be made and made early is suggested by the ever increasing reports of successful surgical removal of these tumors. Since Graham's[3] original report of pneumonectomy only seven years ago, this procedure has been adopted with considerable success by many thoracic surgeons.[4, 5]

It is of more than academic importance, therefore, to make an early diagnosis in these cases. In order to do so, we must know something about the behavior of this disease. It is known that *80 per cent* of the reported cases occur in men, usually of cancer age, sometimes younger[6]. When we look for symptoms on which to base an early diagnosis we find a very discouraging situation: in *20 per cent* or more of the patients, the initial symptoms are extrapulmonary and consist of vague gastrointestinal complaints, weight loss, malaise, et cetera.[7] In addition, King[8] found that *9 per cent* of his patients had their first symptoms from remote metastasis and not from the primary growth itself.

When symptoms referable to the lungs do occur, they are often nonspecific. Cough is usually the most common complaint, then follows chest pain or discomfort, dyspnea, sputum, hemoptysis, in that order. Certainly many diseases of the chest produce these same symptoms.

Our clue, however, lies in the fact that these tumors arise in a bronchus and their growth there has certain consequences. First, there is simple irritation resulting in cough. Erosion of the tumor may occur with consequent bleeding. As the tumor enlarges, it obstructs the passage of air and atelectasis occurs. The vague discomfort in the chest of which these patients so commonly complain is usually due to this atelectasis. Severe pain, it is believed, only occurs

when there has been actual involvement of the pleura.

The occurrence of atelectasis sets up a train of events which is of the greatest importance. The space left free by the partially collapsed lung becomes occupied through a shift of the mediastinal contents and the diaphragm, in cases of long standing by changes in the chest wall as well. These changes can be detected by physical examination or by roentgenography.

Most important of all is the interference with the normal protective mechanism of the lung. Ciliary motion in the bronchial mucosa is impaired, secretions are retained behind the obstructing tumor, and infection occurs. Early in the progress of the disease the obstruction caused by the tumor may be intermittent, and there may be spontaneous remission of symptoms for this reason. Then what we see clinically is a middle-aged man with recurrent "chest colds," so-called, or with bronchopneumonia, which to all appearances runs a normal course; or a patient who for no apparent reason becomes acutely ill with a lung abscess. Spontaneous recovery from these episodes frequently occurs, and it should be emphasized that recovery may appear to be complete, with gain in weight and strength, as after any ordinary acute infection.

More Chronic Infections

With growth of the tumor, and permanent occlusion of the bronchus, more chronic forms of infection may occur such as bronchiectasis with its gradually spreading pneumonitis, and possibly empyema or other pleural complications to mask the original disease.

Such a course of events, when it occurs, takes time. Many of these tumors are slow growing, and the clinical course may be a matter of five to seven years. Ten years ago, Fried[8] in his excellent monograph stressed the prolonged and varied course which patients with carcinoma of the bronchus may present, and it is striking indeed to see the appearance of well-being which some of these patients present one or two years after the onset of symptoms. This is in contrast to the usual course of carcinomas elsewhere in the body. At the other extreme is the fulminating case in which the patient dies within a few months of the onset of symptoms. The first type of patient has a squamous cell carcinoma, the latter an undifferentiated, small cell carcinoma.[2] Adenocarcinoma runs a middle course between these extremes. Location of the tumor in the bronchial tree is another factor which influences the clinical course and prognosis of this disease.

Tuttle and Womack[9] pointed out that tumors arising in the major bronchi produce earlier symptoms, extend more slowly, and are more amenable to surgical treatment. This behavior is attributed to the presence of cartilage in the bronchial wall, acting as a barrier to the tumor.

Bronchoscopic Diagnosis

Tumors in the major bronchi are also more amenable to bronchoscopic diagnosis. This procedure will reveal *60 to 70 per cent* of bronchogenic cancers[6] and, by making tissue available for biopsy, is invaluable in establishing the diagnosis on a firm basis. However, it must be remembered that *30 to 40 per cent* of these tumors are not available to the bronchoscopist. Negative results with the bronchoscope should be followed by exploratory thoracotomy by a competent surgeon in those cases in which good evidence exists for the presence of a cancer of the bronchus.

In this very brief review we have not mentioned physical signs nor the role of roentgenography or bronchography in the diagnosis of this disease. The only characteristic physical findings when they occur are those of atelectasis, namely, impaired resonance and diminished breath sounds over the involved area. When the atelectasis is extensive enough to produce shift of the mediastinal structures, this, of course, can be detected. It is important in considering the roentgenogram to realize that the changes seen on the film are not due to the tumor itself, which is seldom seen, but are due to the results of obstruction of the bronchus.

Despite the many difficulties which arise in making the diagnosis of carcinoma of the bronchus, a few of which we have reviewed here, we have the assurance of no less an authority than Graham that in *75 to 80 per cent* of these tumors a diagnosis is possible.

BIBLIOGRAPHY

1. Jaffé, R. H.: The primary carcinoma of the lung, J. Lab. & Clin. Med. 20: 1227 (Sept.) 1935.
2. Koletsky, Simon: Primary carcinoma of the lung, Arch. Int. Med. 62:636 (Oct.) 1938.
3. Graham, E. A., and Singer, J. J.: Successful removal of an entire lung for carcinoma of the bronchus, J.A.M.A. 101:1371 (Oct. 28) 1933.
4. Overholt, R. H., and Rumel, W. R.: Clinical studies of primary carcinoma of the lung, J.A.M.A. 114:735 (Mar. 2) 1940.
5. Ochsner, Alton, and DeBakey, Michael: Primary pulmonary malignancy, Surg., Gynec. & Obst. 68:435 (Feb. 15) 1939.
6. King, D. S.: Primary cancer of the lung, New England J. Med. 219:828 (Nov.) 1938.
7. Hochberg, L. A., and Lederer, Max: Early manifestations of primary carcinoma of the lung, Arch. Int. Med. 63:80 (Jan.) 1939.
8. Fried, B. M.: Primary carcinoma of the lung, Medicine 10:373 (Dec.) 1931.
9. Tuttle, W. C., and Womack, N. A.: Bronchiogenic carcinoma, J. Thoracic Surg. 4:125 (Dec.) 1934.

Anesthesia Today*

By JOHN S. LUNDY, M. D., R. CHARLES ADAMS, M. D., and THOMAS H. SELDON, M. D.

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THE need for anesthetists has become so acute, both in civil and military medical practice, that the subject should be discussed publicly in the hope that some further progress may be made in providing more individuals who are competent to administer anesthetic agents. The present need also tempts one to try to forecast future developments in anesthesiology, particularly from the standpoint of their bearing on medical practice. In connection with such a discussion, it seems desirable to mention the wide choice of anesthetic agents and methods that is permissible in places where skill in administration is also available. The benefits associated with the development of new methods

* Presented before the meeting of the Medical Society of Milwaukee County, Milwaukee, October 8, 1943.

of utilizing old agents is a part of progress and should be emphasized. In an attempt to give a general picture of the present situation, it seems worth while to touch briefly on them all.

Present Need For Anesthetists

The present global war has resulted in a dispersion of the physician anesthetists formerly available in civil practice. Nurse anesthetists also, although more numerous than physician anesthetists, are relatively scarce. Resort sometimes is made to lay persons for the administration of anesthetic agents. The dental profession may or may not have been sufficiently utilized in anesthesiology. There are few communities that we know of where the need for anesthetists is not urgent, although that need may not be fully recognized now by more than a few individuals. The slow recognition of the practice of anesthesiology as a part of civil medical practice in the past is the reason for the present situation.

Because of the trauma of war, two of the most urgently needed therapeutic measures are relief of pain and measures to combat shock. These activities are in the daily practice of the anesthetist, and it is but natural that his field of usefulness should be in demand in the practice of military medicine. The need for anesthetists in the United States was considerable while the armed forces were gathering their strength, and the necessity of dispatching anesthetists to the many fronts was obvious. These needs carried priority over home front needs. The speed with which the armed forces were expanded made the problem of training anesthetists particularly acute. Many physicians, for the first time, were made aware of the present and future potentialities of the field of anesthesiology. Courses in anesthesia were instituted in several places, and courses as short as twelve weeks were given. Earnest effort on the part of those engaged in these courses resulted in immediate and remote benefits. That is, as the men returned to their stations, they were prepared to act as anesthetists and shortly were training others. Nevertheless, the need for anesthetists ran far ahead of the available supply.

Future Developments in Anesthesiology

The future status of anesthesiology might be considered to be dependent on the trend in medical practice, that is, whether or not state medicine will supplant the present type of medical care. We think it is safe to say, however, that the present demonstration of the importance of anesthesiology and of the need for anesthetists will be carried vividly for some time in the minds of those who will be mustered out of the services and returned to civilian life after termination of the war. Memories associated with the absence of good anesthesia in distant places at various times will be a ready means of stressing the need for development of the field of anesthesiology. We feel that, regardless of the status of medical practice in the future, development of this special field will not be abandoned, and, if we become involved in another war, we trust that we will be prepared for it in every way, including a well developed specialty of anesthesiology.

After the war, the number of anesthetists who can be spared from military service can, and we think will, be absorbed into civilian practice very quickly, and even then the civilian demand will not be properly filled. Hospitals will necessarily have to forego income which they previously derived from anesthesia under conditions which did not develop the field of anesthesiology. It seems to us that, with an increased number of interested workers in the field, many improvements in drugs, technic, equipment and working conditions will naturally follow.

The Wide Choice of Agents and Methods in Places Where the Necessary Skill is Available

The principal need now and in the future will be for skill in the administration of anesthetic agents and in associated activities. In the past, most anesthetists of necessity were self trained. For a few years, there have been available a few centers which offer training for anesthetists, but at present there is not enough uniformity in the training offered so that much can be said of the training centers except that a start has been made. The establishment of a national cer-

tifying board for anesthetists assures a future definition of anesthesiology and of what training will be required to become certified as being properly qualified in that field. Anesthesiology need not be considered to be a narrow specialty, since the qualified individual should feel competent to make preoperative evaluation of the patient and to administer preoperative and preanesthetic medication and care. Management of the patient during operation is a standard practice, but the postoperative care and postanesthetic care of the patient are fields that beckon to the anesthetist so strongly that he must shortly enter them and be mentally prepared to continue in them.

To develop the necessary skill and judgment, it is necessary that the anesthetist be conversant with the fundamentals of anatomy, physiology and pharmacology, but, above all, he must be a relatively good clinician. Moreover, he must have a sufficient amount of practice so that he can develop the manual dexterity which will enable him to produce a maximum of good results with a wide variety of agents and methods. As a matter of fact, wide choice in anesthesia exists only where skill is available along with the drugs and necessary mechanical equipment. A high degree of skill cannot be attained by the average person in a short time. Therefore, the problem of developing a considerable number of skilled anesthetists must be deliberately attacked by having each one prepared to expend the necessary time, energy and money to accomplish this purpose.

New Methods of Utilizing Old Agents

Advances in anesthesia are not necessarily dependent on the development of new agents, although that is a considerable factor, but are also dependent on development of new technics. Especially valuable is any new technic which permits increased use of an old agent. In sacral block anesthesia, the results were good with procaine and with some of the agents of which the effects are of relatively long duration. In the nearly fifty years that spinal anesthesia has been used, progress has been made from first using cocaine to using procaine, metycaine and other agents. Prolonged spinal anesthesia was first made possible by the introduction of new agents of which the effects are lasting, such as nupercaine and pontocaine. Finally, the technic of Lemmon,[1] continuous spinal anesthesia, allowed probably the most desirable agent, procaine, to be employed for anesthesia of whatever duration might be required. As a logical result of the establishment of continuous spinal anesthesia, a new technic for prolonging anesthesia with caudal injections was developed. According to this technic, a needle or ureteral catheter can be so placed that injections can be continued for any period of time if a case is suitable for caudal or sacral anesthesia.

The efforts which have gone into the development of these phases of anesthesiology have been the result of a great many years of work on the part of a relatively large number of individuals in many fields. At the moment, continuous spinal anesthesia is being carried out by at least one anesthetist with an indwelling catheter as well as with an indwelling needle.[2] The quiet suggestion of one who has worked scientifically over a period of time was that of Cleland,[3] who suggested caudal and paravertebral anesthesia for obstetric analgesia in 1933. His contribution did not receive the wide notice that was given subsequently to the work of Edwards and Hingson.[4] These are examples of the extremes of lack of emphasis on the one hand and of overemphasis on the other hand. Cleland's suggestion, taken seriously and put into effect, should have resulted in clinical application of local anesthesia for relief of pain in labor and delivery. The fact that Cleland's paper did not excite such an effort illustrates how easily progress is halted through lack of quick understanding. The publication of Edwards and Hingson, based largely on clinical experience, was given very wide publicity, and, in many instances, this publicity was embarrassing to the authors. Nevertheless, the combined efforts of Cleland and of Edwards and Hingson may make available a very useful procedure in selected obstetric cases.

Selection of Anesthetic

The selection of the anesthetic agent in such cases is dependent on cooperation of the anesthetist and obstetrician, in the same way that choice of the anesthetic agent for a surgical case is worked out between the surgeon and the anesthetist. Not all obstetric cases are suitable for continuous caudal anesthesia for a variety of reasons. Conversely, the method is not an available one unless someone is present who can successfully carry out the technic. It will be some time before continuous caudal anesthesia can be assigned its proper place in present-day medical practice, and its place in the immediate future will be greatly restricted, in all probability, as compared with, or in contrast to, its place in the remote future. So far as we are able to say, there are very few procedures in anesthesia that can be followed routinely with optimum results.

Judging from Cleland's work, we might say that if anesthesia were carried up to and including the eleventh thoracic segment, but no higher, on each side, there would be no pain for the mother and there would be no interference with contractions of the uterus. Conversely, many patients have a considerable systemic effect, as well as a local effect, from local anesthetics. For these people, contractions of the uterus may be stopped because of the systemic effect of the drug, regardless of the exact level of cutaneous anesthesia that has been produced.

The question of who shall carry out the procedure of continuous caudal anesthesia cannot be settled for everybody by a few. The question has already arisen whether it should be a function of nurse anesthetists or of physician anesthetists. A new procedure requires long investigation and application before it can be properly evaluated, and the present enthusiasm for the method will not be sustained unless the method proves to be worthy of that enthusiasm. Many unqualified persons will attempt it, and their failures will be attributed to the method rather than to other inadequacies. Future success will depend on the training and teamwork necessary to success.

Progress in anesthesiology includes treatment of disease by inhalation of gases such as oxygen; this should be an integral part of the clinical practice of those who administer anesthetic agents by inhalation. The ready availability of the anesthetist in the hospital makes him a logical person to carry out the clinical application of oxygen therapy. Because of the interest in anesthesia and therapy by inhalation, the anatomy and physiology of respiration have become extremely important to the anesthetist. In some cases, he has taken up bronchoscopy so that he may carry out bronchoscopic examination and aspiration of the air passages at the termination of anesthesia as prophylaxis against the occurrence of pulmonary complications, especially atelectasis.

In a further development of regional anesthesia, blocking of nerve trunks has become the function of the anesthetist in connection with injections for diagnosis as well as injections for therapeutic purposes and for prognosis preliminary to proposed surgical interventions.

Complete Records

The results associated with the ever expanding field of anesthesiology have meant that most complete anesthesia records must be maintained. Accordingly, the statistician has been appealed to, and he has been of great help in evaluating the results obtained.

To those of us who have been closely associated with training in anesthesia for some years, it has seemed that after each period of ten or twenty years a new cycle of development tends to begin. This view seems to be borne out. In 1925, one of us made the statement before anesthetists, who at that time limited their work almost entirely to the administration of anesthetic agents by inhalation, that in a few years they should be able to do local, including regional, anesthesia if they wished to retain leadership in the presence of competition that would eventually be offered by those who could do both types of anesthesia. We are satisfied that the prediction at that time was sound, and later, in 1935, it seemed clear that intravenous anesthesia must be added to the repertoire of the anesthetist.

Advances Must Be Published

Advances in clinical anesthesia must be paralleled by advances in essential knowledge and research acquired in the laboratory and disseminated through the published literature so that work of merit will not be semipermanently overlooked. Publications on anesthesia in periodical and book form, such as "Current Researches in Anesthesia and Analgesia," "Anesthesiology," "Endotracheal Anaesthesia" by Gillespie, "Clinical Anesthesia" by Lundy, "Fundamentals of Anesthesia" by the Subcommittee on Anesthesia of the National Research Council, and Adams' forthcoming monograph, "Intravenous Anesthesia," are necessary to progress in the subject since they disseminate knowledge, stimulate inquiry and, incidentally, place authors under the necessity of organizing their own thinking and summarizing their own results.

The printed page is an old agency that has great potentiality for the progress of man. As is true of the agents and methods mentioned in the immediately preceding paragraphs, the printed page must be used for new purposes as anesthesiology advances.

We hope that we have made evident that anesthetists are greatly needed at the present time and will be needed increasingly in the future. This future need will spring, just as the present need has arisen, from developments in the field of anesthesiology, including new agents and methods and new applications for old agents and methods.

BIBLIOGRAPHY

1. Lemmon, W. T.: A method for continuous spinal anesthesia, Ann. Surg. 111:141 (Jan.) 1940.
2. Tuohy, E. B.: Unpublished data.
3. Cleland, J. G. P.: Paravertebral anesthesia in obstetrics, Surg., Gynec. & Obst. 57:51 (July) 1933.
4. Edwards, W. B., and Hingson, R. A.: Continuous caudal anesthesia in obstetrics, Am. J. Surg. n. s. 57:459 (Sept.) 1942.

The Treatment of Meningococcic Meningitis

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MENINGOCOCCIC meningitis is a disease which requires immediate action on the part of the physician, followed by adequate treatment. Adequate treatment involves three "agencies": (1) the medical attendant, (2) the laboratory, and (3) the nurse. This paper attempts to summarize those procedures which we feel to be of importance. For the sake of clarity, they are discussed in semioutline form. It is not, however, our intention to convey thereby an impression of dogmatism but rather to "highlight" those points in the diagnosis and treatment of meningococcic meningitis which appear essential and are not infrequently overlooked.

Immediate Action

Immediate action assumes early diagnosis. This is facilitated if the following factors are kept in mind:

A. *History*

Incubation period of one to ten days.[1] The onset of the disease is usually preceded by prodromal symptoms of malaise, gastrointestinal complaints including nausea and vomiting, generalized aching, fever, often mental confusion, and a headache which tends to increase in severity. Occasionally, the patient notes the appearance of "spots" on the extremities and trunk which may be mistaken for atypical varicella. The history of

other known cases of meningitis to which the patient has been exposed may or may not be available.

B. *Examination*

Examination reveals most characteristically a toxic-appearing individual with fever ranging from 100 F. to 105 F., pulse full and bounding, little to considerable mental alteration, general hyperesthesia to touch, stiffness of the neck, mild to marked opisthotonos, not infrequently small scattered petechiae on extremities and trunk, Babinski, Kernig, and/or Brudzinski signs suggestive or positive.

In our opinion, such a history and findings warrant an *immediate* lumbar puncture.

C. *Lumbar Puncture*

As a rule, this is best done in the third to fourth lumbar space. If there is reason to anticipate a marked increase in cerebrospinal fluid pressure, the foot of the bed may be elevated. If the degree of opisthotonos does not permit a puncture in the lumbar region, a cisternal puncture should be performed by one experienced in that type of procedure. If the lumbar route is used, spinal fluid pressure should be taken. If laboratory facilities are *immediately* available, sufficient spinal fluid should be withdrawn from either region for cell count and differential, sugar, protein, colloidal gold test, Wassermann, and stain for predominating organisms. In addition, a sterile tube should be partially filled for culture. An immediate request should be made for (1) *cell count*, (2) *sugar*, and (3) *identification of predominating organisms.*

The following table contrasts the normal cerebrospinal fluid findings with those characteristic for meningococcic meningitis.[2]

If complete laboratory facilities are not *immediately available* and gross inspection has revealed a fluid which appears cloudy, opaque, or purulent, the examiner should himself prepare to do an immediate cell count and stain for predominating organisms. While it is true that fluid which is grossly cloudy or purulent furnishes strong presumptive evidence for meningococcic meningitis, similar appearing fluid may also be found in syphilitic meningitis, brain abscess, sinus thrombosis, extradural abscess, and occasionally poliomyelitis. From one point of view, it may be considered that "sulfa" therapy will be helpful in some of the above and of no harm in others, but it seems unwise to us to subject a patient to the large doses required for the treatment of meningitis unless it is clearly indicated, for sensitization to the drug may thus be acquired without any compensatory gain for the individual. However, in isolated regions or in situations where even the few essentials required for fluid examination are lacking, a physician would, we feel, be justified in proceeding with "sulfa" therapy—basing his rationale for treatment upon the history and examination supported by a grossly cloudy, opaque, or purulent fluid.*

As soon as the diagnosis has been established, but before treatment is begun, 10 cc. of blood should be withdrawn from the patient and sent to the laboratory for culture for meningococci.

* *Directions for staining.* Unless fluid is extremely opaque, centrifugalize specimen for two to three minutes. Place one drop of cerebrospinal fluid to be tested on a clean slide and fix with heat. Stain with gentian violet for one minute, then flood with Gram's iodine; let stand on a flat surface for one minute. Decolorize with 95 per cent alcohol; wash with tap water and counterstain with safranine. Examine under microscope for gram-negative (red) diplococci.

	Gross Appearance	Pressure in mm. of Water Horizontal Position	Cells	Sugar	Protein	Gold Sol	Organisms
Normal	Clear, colorless	70–180	0–5	50–85 mg. per 100 cc.	15–45 mg. per 100 cc.	0000000000	0
Meningococcic Meningitis	Cloudy, opaque, purulent	200–700 (may not be elevated if subarachnoid block is present)	500–30,000, chiefly polymorphonuclears	0–45 mg. per 100 cc.	50–100 mg. per 100cc.	Variable rarely in first zone	Meningococci

Therapy

Efficient therapy begins with the use of a "sulfa" drug. While it is probably correct that any of the sulfonamides are efficacious, and while it is also probably correct that certain patients who show little improvement on one "sulfa" drug may display marked improvement on another, it is our impression that sulfadiazine is the drug of preference in the treatment of meningococcic meningitis with sulfanilamide, sulfapyridine, and sulfathiazole as second choices.

A. *Initial dose of sulfadiazine*

For a normal sized, previously healthy adult, 4 to 5 Gm. of sulfadiazine constitutes the initial dose. (Sulfadiazine is prepared in ½ Gm., 7½ grain, tablets.) This size dose finds support in the work reported by Finland, Peterson, and Goodwin[3] and by Dingle, Thomas, and Morton.[4] The impression is gained that *the initial dose should be the largest compatible with the size, age, and health of the individual.* Other things being equal, the physician should not hesitate to "hit hard and fast."

B. *Route of administration (in the order of preference)*

1. *Orally.*

To be recommended unless the patient is (a) nauseated or vomiting, (b) extremely ill so that a more rapid method must be used, or (c) comatose. To facilitate absorption, the tablets may be crushed before administering.

2. *Nasal catheter or stomach tube.*

The initial dose of sulfadiazine is pulverized to permit easy passage through a tube and administered in a small amount of water. This method is recommended when the patient is (a) comatose or (b) for some other reason unable to swallow. By this route, absorption is rapid and the difficulties of intravenous or subcutaneous methods avoided.

3. *Intravenously.*

Indicated whenever (a) a rapid method of administration is called for, or (b) the patient is unable to retain the drug by mouth or tube. In this method, sulfadiazine is given in the form of *sodium sulfadiazine,* a powdered substance *which must have been previously sterilized.* (It has been our practice here to keep on hand sterile tubes containing previously measured amounts of the drug.) The initial dose of 5 Gm. of sodium sulfadiazine is dissolved *just prior* to administration in 100 cc. of fresh sterile distilled water, thus making a 5 per cent solution. Great care must be taken to prevent the solution from entering the tissues, for in a 5 per cent solution the alkalinity is sufficient to produce a slough. The 100 cc. is given most conveniently in the form of an intravenous drip. During this procedure, restlessness of the patient may require constant supervision to prevent moving of the arm, leakage, et cetera. Nembutal, 2 grains, in the form of a suppository may be helpful in obtaining sedation. *Caution.* While giving intravenous sodium sulfadiazine, blood transfusions or intravenous glucose injections are to be avoided.

4. *Subcutaneously.*

Five Gm. of sodium sulfadiazine may be given in *500 cc.* of sterilized physiologic saline, making a 1 per cent solution. Spink[5] states that he has "had satisfactory results from giving sodium sulfadiazine subcutaneously." (Apparently, in a 1 per cent solution the danger of sloughing is slight.) The hypodermoclysis should be permitted to run between 250 to 300 cc. per hour. In comparison to the intravenous method, it may be stated that the subcutaneous route offers less chance for tissue damage and is easier to give.

Sulfadiazine *should not* be given either intrathecally, intramuscularly, or by rectum. If the initial dose or the first few following doses must be given intravenously or subcutaneously, the remainder should be given by mouth as soon as the patient is able to swallow and retain them. Recent work[6] appears to indicate that soda bicarbonate in 1 to 2 Gm. doses, given in combination with sulfadiazine, tends to reduce crystal formation.

C. *Continued therapy*

1. After the initial dose (which in some severe cases may have to be repeated in four to five hours) the patient may be placed on 1 to 2 Gm. every four to six hours, day and night. In certain severe cases, larger amounts may be required or it may be found advantageous to decrease the time interval of administration to every two hours. The amount and the time are best determined by a careful individualization of each case, taking into account the severity of the disease, the response of the patient, and the blood level of sulfadiazine. As a rule, after two to three days the time interval may be increased so that 1 to 2 Gm. are given every six hours, the patient being kept on that schedule (other things being equal) for four to five days. It is obvious that it is neither possible nor desirable to be dogmatic in this matter of continued dosage. (In one of our cases, after the fifth day the patient was maintained on 1 Gm. three times a day. In another case, the dose was continued at 2 Gm. every six hours through the eighth day.) In general, however, the drug should not be discontinued until after the tenth to twelfth day of its administration, for, if stopped earlier, there may be an exacerbation of the meningitis.

2. The first twenty-four hours of the disease constitutes one of its most important, if not *the* most important phase; therefore, the presence or absence of clinical improvement during this period is of extreme significance. Clinical improvement may be estimated on the basis of a fall in temperature, pulse, and leukocyte count, decreased neck rigidity, and greater mental alertness. If these findings are not present, one of three things should be considered:

(a) Increase in the amount of sulfadiazine if the sulfadiazine blood level and the urinary output permit.

(b) Shift to another of the sulfonamides as sulfanilamide or sulfapyridine.

(c) Utilization of antimeningococcic serum. The use of antimeningococcic serum in relation to chemotherapy is, as Dingle and Finland[1] state, "difficult to define." However, there seems to be a growing feeling that in most cases adequate chemotherapy will be sufficient and that the use of serum should be considered only where there is insufficient improvement within the first twenty-four hours. If the type of meningococci is known and specific antiserum for the type or group is available, this should be used in preference to the polyvalent antimeningococcic serum. Some investigators[7] have suggested the use of antitoxin. The serum may be given intramuscularly (in divided doses in each buttock) or intravenously. Inquiry for an allergic history and testing for sensitivity to horse serum and, if necessary, desensitization must be done first.* The amount of serum necessary can best be determined by repeated examinations of the patient's blood until an excess of antibodies, sufficient to cause agglutination of the meningococci, is demonstrated. The amount of serum required for this may vary in amounts from 20 to 100 cc. If the serum is to be given intravenously, it is advisable to dilute it with a sterile, warm, normal saline solution to which have been added a few minims of adrenalin. The serum should *not* be given intrathecally.

D. *Daily procedure which should be carefully carried out on each patient*

(1) Clinical examination, with particular attention directed to the general attitude of the patient, mental alertness or sluggishness, type of complaints, evidence of confusion or psychosis.

Visual changes and complete ophthalmoscopic examination for edema, hemorrhages, and exudates. (Inasmuch as frequent lumbar punctures are not in order, ophthalmoscopic examination is of importance as a check on intracranial pressure.)

Examine the neck for decrease or increase in rigidity.

Ears for otitis media or deafness.

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* The method of desensitization recommended by Merritt and Fremont-Smith[8] is as follows: "Intracutaneous injection of 1/20 cc. of antimeningococcic serum controlled by the injection of a similar amount of saline. . . . If the patient is sensitive to the serum he is desensitized by gradual doses of the serum intracutaneously, subcutaneously, and intramuscularly."

Chest for pneumonia, bronchitis, or pleurisy.

Heart for pericarditis, endocarditis, myocarditis, or enlargement.

Abdomen for rigidity, fullness of bladder, et cetera.

Genitalia in male for orchitis or epididymitis.

Skin for petechiae or edema.

Extremities for arthritic changes, edema, and reflexes.

(2) Temperature, pulse, respiration, and blood pressure should be taken and recorded every two hours for the first twenty-four, thereafter three times a day. Various respiratory disturbances may be noted, such as the Biot or Schlesinger types, more rarely Cheyne–Stokes.

(3) Intake and output should be recorded for each twelve hour period.

The above list is designed not only to yield necessary information as to the status of the patient in regard to his meningitis but also to take into account the principal complications and sequelae which may develop. A bedside chest plate or electrocardiogram may be required.

E. *Laboratory*

a. For the *first week,* obtain *daily* complete blood count and uranalysis. In the blood count, special attention should be paid to anemia, leukocytosis and inversion of white count. In the uranalysis, special attention should be paid to the specific gravity, presence of albumin, red blood cells, and sulfadiazine crystals. (Four plus glycosuria was noted in one of our cases with a blood sugar of 152. There was no history of previous diabetes. The condition cleared within a few days, leaving the impression of a possible diencephalic disturbance as a result of the meningitis.)

b. During the *first week, daily* blood level determination of sulfadiazine should be made. (It is felt by many that it is highly desirable to obtain a blood concentration of 15 to 18 mg. per 100 cc. as rapidly as possible. Concentration should not be permitted to rise over 18 mg. per 100 cc., and is best held at 10 to 12 mg. per 100 cc. after the initial rise.)

c. Blood chlorides taken before the administration of fluids will be helpful in estimating the initial amount of saline required.

d. Alkali reserve should be obtained since acidosis is not uncommon.

F. *Fluids*

With the use of sulfadiazine, it is essential that fluids be pushed. Ideally they should be kept at 4,000 to 5,000 cc. per twenty-four hours for at least the first four days. They should not be permitted to fall under 3,500 cc. so long as sulfadiazine is being used in any significant amount. If taken by mouth, fluids may consist of water, fruit juices, milk, et cetera. If the patient is unable to take them by mouth, they may be given as follows, in a twenty-four hour period:

Subcutaneously. Normal saline not to exceed 1,000 cc. (unless the initial blood chloride shows a decrease or there is clinical evidence to suggest hypochlorhydria, in which case initial saline may be increased but should be cut not to exceed 1,000 cc. as soon as the chloride deficiency has been met). The saline may be combined with 2,500 cc. of 5 per cent glucose in sterile distilled water, making a hypodermoclysis total of 3,500 cc.

Intravenously. 1,500 cc. of 5 per cent glucose in sterile distilled water to make a grand total of 5,000 cc.

(As has been noted above, the intravenous glucose should not be given if sulfadiazine is also being administered by this route.)

In patients showing clinical evidence of acidosis or whose alkali reserve is below 40, lactate Ringer's solution may be used. This is at present available in 20 cc. ampules (Lilly). The directions state that dilution must be twenty-five times. If uncertain of the amount to give, it is safe to estimate 10 cc., after dilution, per kilogram of body weight, unless the acidosis is very severe.

The above fluid suggestions may be followed in general *whenever the age and general condition of the patient permit.* However, it is important that a sufficient amount of fluid be given to permit the excretion of the sulfonamide, and it is unwise to use amounts of saline over 1,000 cc. (unless combating an initial hypochlorhydria) because

of the danger that fluids may be retained in the tissues. Parenteral fluids should be discontinued as soon as the patient can take them orally.

G. *Output*

The urinary output for twenty-four hours should not be permitted to fall below 1,500 cc. If the patient is unable to void, catheterization at regular eight hour intervals is indicated. (Several of our male patients had difficulty in using the urinal in a lying position but were able to void if permitted to hang their legs over the side of the bed while their chest and head remained in a horizontal position. It was felt that with supervision and support to prevent falling, the slight exertion involved in this procedure, especially after the first twenty-four hours, was preferable to catheterization at frequent intervals or to the irritation of an indwelling catheter.) If, despite the pushing of fluids, the urinary output should fall *below* 800 cc. in twenty-four hours, and in the presence of erythrocytes, sulfadiazine crystals, or if anuria develops, 50 cc. of 50 per cent glucose may be given intravenously, and fluids may be increased. If no improvement occurs within six to eight hours, ureteral catheters should be installed for kidney lavage. Fox, Jensen, and Mudge[6] suggest the use of alkaline bicarbonate or carbonate solutions in lavage, as there is evidence that these substances will dissolve drug crystals more efficiently than warm water or isotonic saline. If the urinary output falls to 1,000 cc., it is advisable to discontinue sulfadiazine temporarly until the output is again normal.

H. *Diet*

In the first twenty-four to forty-eight hours, the diet is usually liquid, thereafter soft and, as a rule, after seventy-two hours, high caloric. Essential vitamins should be started from the first day of therapy. (For the first three days it may be advisable to give these by hypodermic, 25 mg. of thiamin chloride and 10 mg. of riboflavin. Thereafter, one of the multiple vitamin compounds may be given daily by mouth.)

I. *Sedation*

For restlessness associated with nausea, nembutal suppositories, 2 grains, may be found useful, or the patient may be given 2 to 3 cc. of paraldehyde intramuscularly. It is our impression that large doses of barbiturates should be avoided. In 3 cases, we have noted respiratory embarrassment and cyanosis where the dosage was greater. It seems wiser to use small amounts which may be repeated at necessary intervals. For persistent headache, codeine, ½ to 1 grain by hypodermic, appears effective.

J. *Repeated lumbar punctures*

After the initial diagnostic puncture, other taps should be avoided as much as possible. After eight or nine days on chemotherapy, a second spinal tap may be done to ascertain the fall in cell count, rise in sugar, and decrease in organisms. Some workers like to have a normal fluid before the patient is discharged, and if this is felt to be desirable, a third puncture might be done during the last days of hospitalization. More frequent punctures would be indicated (a) if the patient were failing to respond properly to treatment, especially within the first twenty-four hours. Here the increase or decrease in cell count and especially in cerebrospinal fluid sugar would be of value in prognosis and in the question of therapy. (b) For the relief of increased intracranial pressure as shown by continued projectile emesis. (c) Rarely for severe headaches which are not relieved by codeine.

K. *Increase in blood sugar*

In those cases showing increase in blood sugar together with glycosuria, 10 units of insulin may be added to the first 700 cc. of 5 per cent glucose given subcutaneously. The additional or continued use of insulin may be determined by following blood and urine sugar levels.

L. *Nursing care*

Whenever possible, special nursing care should be arranged for the first forty-eight hours.

M. *Quarantine period*

According to the Wisconsin State Board of Health regulations,[9] the quarantine period exists for "at least two weeks from the time the case is reported and until temperature

has become normal." As a rule, if the patient's progress is satisfactory, he may be encouraged to sit on the edge of his bed after the eighth or ninth day and be up on the tenth to the fourteenth day. Considerable fatigue and weakness may be present for some weeks, even in young healthy adults. It is felt that induction into the armed forces should not be contemplated until at least two months have elapsed. If there have been complications, the time interval should be longer.

N. *Others exposed*

In the case of those individuals who have been *immediately* exposed to the patient, it is well (from a psychologic point of view if from no other) to obtain cultures of the nose and throat and to place the individuals under supervision, with instructions to report at once if they note any of the prodromal symptoms. Whether or not sulfadiazine in small amounts should be given to those who have positive cultures is debatable.

O. *The Waterhouse–Friederichsen Syndrome*

This unfortunate and usually fatal complication of meningococcic meningitis is characterized by (a) very few meningeal signs, (b) large and numerous petechiae, and (c) a falling blood pressure. The symptoms are explained on the basis of a hemorrhage into the adrenal glands. For this reason, the necessity for repeated checks on blood pressure and the observation of petechiae was noted earlier in this article. The prompt initiation of chemotherapy will probably do much to forestall this phenomenon. However, if it is noted that the blood pressure is low and shows signs of falling, we feel that it is wise to administer adrenal cortex, 10 cc. intravenously, followed thereafter by 5 cc. intramuscularly every four hours until the patient shows improvement.

P. *Indications to stop sulfadiazine therapy*

(a) Normally after ten to twelve days of treatment.

(b) Promptly in event of (1) urinary shutdown, (2) progressive hemolytic anemia, (3) marked and continued inversion of the differential white cell count for four or five days.

Conclusion

While meningococcic meningitis is a serious condition, it is our impression that the mortality rate can be substantially lowered if the above points in diagnosis and therapy are followed. In those cases where death occurred, a check-up has usually revealed (a) a lapse of many hours or even days in making a diagnosis, (b) inadequate sulfonamide therapy, (c) the use of too large amounts of saline with marked tissue edema and retention, (d) overdosage with barbiturates resulting in medullary compression, (e) occasionally overdosage with sulfadiazine resulting in fatal renal complications.

NOTE: Since this paper was submitted for publication in July, 1943, several written reports have been made on the treatment of meningococcic meningitis with sulfamerazine. We have had no personal experience with this drug, but the articles by Hall and Spink[10] and Lepper, Sweet, and Dowling[11] indicate that sulfamerazine is as effective as sulfadiazine and less toxic. It is our intention to use this drug in the treatment of the next cases of meningococcic meningitis.

BIBLIOGRAPHY

1. Dingle, J. H., and Finland, Maxwell: Diagnosis, treatment and prevention of meningococcic meningitis, War Med. 2:1 (Jan.) 1942.
2. Merritt, H. H., and Fremont–Smith, Frank: The cerebrospinal fluid, Philadelphia, W. B. Saunders Co., 1938.
3. Finland, Maxwell; Peterson, O. L., and Goodwin, R. A.; Sulfadiazine; further clinical studies of its efficacy and toxic effects in 460 patients, Ann. Int. Med. 17:920 (Dec.) 1942.
4. Dingle, J. H.; Thomas, Lewis, and Morton, A. R.: Treatment of meningococcic meningitis and meningococcemia with sulfadiazine. J. A. M. A. 116:2666 (June 14) 1941.
5. Spink, W. W.: Sulfanilamide and related compounds in general practice, Chicago, Year Book Publishers, 1942, p. 41.
6. Fox, C. L., Jr.; Jensen, O. J., Jr., and Mudge, G. H.: The prevention of renal obstruction during sulfadiazine therapy. J. A. M. A. 121:1147 (Apr. 3) 1943.
7. Hoyne, A. L.: Epidemic meningitis, J. A. M. A. 115:1852 (Nov. 30) 1940.
8. Merritt, H. H., and Fremont–Smith, Frank: The cerebrospinal fluid, Philadelphia, W. B. Saunders Co., 1938, p. 230.
9. The prevention and control of communicable diseases in the State of Wisconsin, Wisconsin State Board of Health, Madison, 1942, p. 8.
10. Hall, W. H., and Spink, W. W.: Sulfamerazine, J. A. M. A. 123:125 (Sept. 18) 1943.
11. Lepper, M. H.; Sweet, L. K., and Dowling, H. F.: The treatment of meningococcic infections with sulfadiazine and sulfamerazine, J. A. M. A. 123: 134 (Sept. 18) 1943.

Medical Control of Poisons in Industry*

By ELSTON L. BELKNAP, M. D.
Milwaukee

E. L. BELKNAP

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THIRTY years ago, practically all the physicians connected with industry were industrial surgeons. Formerly, industrial injuries were chiefly those requiring amputation or surgical intervention after wound infection. Now the engineers with their mechanical guards have largely eradicated industrial accidents. And industrial medicine is now, therefore, chiefly the application of methods of internal medicine to maintain the health of the worker in industry and the study of the effect of toxic substances on the blood and vital organs. If they will open their eyes and apply themselves, the majority of the medical profession can take an active part in the study and practice of industrial medicine.

I will limit my discussion primarily to poisons of industry. Physicians in industry are continually studying the problems of chemical warfare, whether in factories under peacetime conditions or under conditions of wartime bombing. Most modern industries are now based upon chemical processes, often necessarily involving the use of poisons. Due to the exigencies of war, we are having to return to the use of older toxic solvents because the safer substitutes are required for the manufacture of explosives. The industrial hazard is further increased by having to expose women and adolescent males to poisons of industry, but we are confident that these poisons may be used with safety under conditions of adequate medical control.

Principles of Adequate Medical Control

The first principle of control with which the physician in industry must acquaint himself is a knowledge of the mechanism of absorption and action of poisons. In industry, as well as under conditions of chemical warfare, the chief portal of entry for these poisons is by inhalation, and the point of attack is either directly on the respiratory tract or remotely by action on the kidneys, liver, heart or central nervous system. First, the action of the poison may only be irritating to the upper respiratory tract as with sulfuric acid and chlorine vapors. These have no real systemic effect. Second, the action of the poison at the portal of entry may be silent, but there may be a delayed effect on the lung as with phosgene and oxides of nitrogen. Third, there may be a possible toxic systemic damage to the liver, kidneys, and blood system as with the mineral poison lead and volatile solvents as well as with the war gas, lewisite, though the latter also has a serious local caustic effect. Finally, the action may be asphyxiant with immediate depressant action on the central nervous system as with hydrogen sulphide, cyanide, and carbon monoxide.

Physician Can Be Key Figure in Field of Industrial Poisoning

Just as the physician is a key figure in the chemical warfare service, so he can be the key figure in the field of industrial poisoning. He must realize that he is the expert to whom the Army, civilian defense, or industry must first appeal for aid. Of course, if the physician is able to give no answer, these agencies will naturally turn to lay groups.

* Presented before the Postgraduate Industrial Medical and Surgical Clinic of the State Medical Society of Wisconsin, Milwaukee, November, 1942.

If the physician does not have the initiative or interest to keep himself abreast of the new developments in chemical warfare, or in the chemistry of industry, then he must not be surprised if he is finally relegated to a position of secondary importance. It therefore behooves the physician to be informed if he would retain his natural commanding position.

Regardless of special training or interest, every physician should know not only the basic principles of first aid, but he should know the rudiments of the principles of underlying toxicology both in war and in industry. Although these principles are simple, they must not be underestimated. The application of these principles in industry is made possible by simple technics already part of the training and experience of every physician. These include a careful history, especially of the occupation, together with a verbatim account of the present illness. Every physician now knows the established minimum of a complete physical examination and laboratory study including a routine blood count and uranalysis. These methods of observing and recording facts are familiar to every trained physician. But in industrial medicine we must study pictures already familiar to all of us in our general practice to interpret these findings in their relationship to the poison.

In industrial medicine we do not have years of precedent to follow, but we can apply our common sense and medical experience in the correlation of facts carefully gathered. The following has been our method of approach. At first, when a series of disabling and costly poisons stirred the employer, he demanded investigation of conditions at his plant, and all of the workers exposed to a particular poison were surveyed. When the number of workers showing actual evidence of absorption of the poison had been noted, the severity of the exposure could be measured. These cross section surveys merely indicated the intensity of exposure in a certain spot at a given time. They did not prevent disability. It was only when we began to make systematic, periodic reexaminations that we became aware of an impending trend towards poisoning or intoxication and thus prevented disability. Then we could begin to correlate the intensity of exposure as determined by engineering methods with the actual risk of poison intoxication. When we could predict such intoxications and treat or move a worker in time, then we could insure prevention of disability. Finally, when the medical department can be used as a check on the complete adequacy of protective engineering devices, we have the ideal control of poisons in industry.

Let me illustrate with a few instances of the commonest toxic substances used in industry, namely, toxic dusts, toxic solvents, and toxic gases. The theory and practice of medical control of poisons necessary to industry can best be illustrated by discussing the commonest of mineral poisons, namely, lead. Because of its wide range of safe dosage, we need have no unreasoning fear of lead any more than we have of mustard gas in the chemical warfare service. In chemical warfare, if we go to the second or third story of our home instead of the basement, we need not fear mustard gas even without a respirator. It will, of course, be a nuisance, but we do have methods proved by experience with which we can control even this irritant gas. So, if we remember that lead in small doses is excreted almost as rapidly as it is taken in, we do not fear small repeated doses of lead.[1] By studying the blood picture, both hemoglobin and stippled cell curve, we can gauge the safe level of lead absorption. I refer to lead as an excellent example of toxic dust because it is the commonest poison in industry.

Lead Is Hazard in Twelve Common Industries

The twelve most common industries involving the use of lead as a hazard are: the storage battery industry, streamlining of welded irregularities, painting, torch cutting of painted steel, smelting of lead or scrap metal, pottery making, enameling, printing, soldering and tempering, brass foundries, ink making, and the manufacture and application of insecticide.

The diagnosis of lead poisoning rests upon a history of adequate exposure plus the characteristic pattern of both symptoms and

signs, physical and laboratory.[2] Usually, the symptoms are anorexia, constipation, and violent abdominal colic coming on with the onset of complete constipation or obstipation.

Real Lead Poisoning Is of Three Types

Real lead intoxication or lead poisoning consists of three types: (1) lead colic, making up 90 per cent of the cases, (2) lead palsy, making up 5 to 7 per cent, and (3) lead encephalopathy making up 2 to 3 per cent. All experts in the field of industrial toxicology agree that it is essential to distinguish between nondisabling lead absorption, which is not lead poisoning, and disabling lead intoxication, which is lead poisoning.

Besides the characteristic pattern of symptoms outlined above, there are certain helpful physical and laboratory signs which point to lead absorption. One is the lead line of the gum, which is a definite row of dots determined precisely by the use of the hand lens. Another is the demonstration of stippled cells on a blood smear ranging from five to ten per fifty fields or 500 to 1,000 per million red cells. These are best shown by the use of a Wright blood stain with which every physician is familiar when he makes a differential blood count. While neither a lead line nor a few stippled cells indicate anything more definite than probable lead absorption, they certainly do not in themselves indicate lead poisoning. The one laboratory sign which is consistently associated with clinical lead intoxication, or lead poisoning, is at present the stippled cell curve usually rising from twenty per fifty fields to over a 100 per fifty fields. The determination of lead in the urine is helpful as a confirmation of lead absorption. Of itself, quantitative examination of the urine for lead does not diagnose lead intoxication.

In another paper[3] I have discussed in detail the treatment of acute lead poisoning and its residuals.

Principles of Prevention

From an experience with several hundred cases of lead absorption and lead intoxication studied over a period of twenty years, I would now give this practical advice to the physician who is called upon to analyze such an occupational disease as lead poisoning by recommending the following principles of prevention:

(1) Selection of employes by eliminating those who are over susceptible, that is, women, adolescents, and individuals with metabolic abnormalities such as diabetes and hyperthyroid tendencies.

(2) Frank concentration of risks where workers appreciate their danger and take full advantage of all safety measures.

(3) Adequate control by frequent physical and blood examinations of the few workers exposed.

(4) Insistence upon prompt moving of the worker who shows unsafe levels of absorption.

(5) Investigation of each case by the physician with personal first-hand study in the plant. That is, the physician must become familiar with the entire operation by unannounced observation of the worker at work, asking questions freely of both employes and supervising personnel.

(6) Control of inspection and maintenance of protective respirator devices by the medical department.

Toxic Solvents

While lead is an example of the common toxic dust, there is another large group of substances occurring almost as frequently in industry and really of much greater danger than lead. These substances are the toxic solvents. One of their large subdivisions is the chlorinated hydrocarbons, such as trichlorethylene, ethylene dichloride, carbon tetrachloride, and tetrachlorethane, listed in order of increasing toxicity. These substances are used as textile cleaners, metal degreasers, lacquer and cement solvents, as well as thinners for nitrocellulose materials. For the purpose of a practical illustration, I will now report on an experience I had recently with carbon tetrachloride, regarded by lay persons as one of the least toxic of the chlorinated hydrocarbons.

A young man, aged 30, was especially skilled in relaying old linoleum. To remove the old cement from beneath the linoleum, he used gasoline. He had done this for ten years with no symptoms. One

morning, however, he was furnished with a gallon of a substance which he was told would be harmless and much more effective than the gasoline. He spent one day in a basement on his hands and knees, in a small compartment, removing the cement for relaying linoleum with this new and very effective solvent, (later found to be CCL 4). Towards the end of the day, he felt somewhat dull but did not really feel sick until the second day, when he became nauseated. By the third day he had such abdominal cramps and vomited so much that he could not go to work. Shortly, he developed a severe headache and then anuria with signs of uremia and a high blood pressure and difficulty in vision. In spite of calcium and blood plasma given intravenously with various types of supportive therapy, this man finally died of uremia ten days after the onset of symptoms. An autopsy was done which showed a typical acute kidney damage of the nephrosis type which one expects in acute carbon tetrachloride poisoning. It was very similar to the pathologic findings of bichloride of mercury poisoning. Besides kidney damage, however, there was also acute damage to the liver and to the heart muscle.

While this is the end result of an acute chlorinated hydrocarbon poisoning, chronic poisoning due to smaller doses is also possible. This causes nausea and headaches with an occasional development of jaundice as well as a possible damage to the kidneys. Not all chlorinated hydrocarbons act in the same way. Trichlorethylene seems to be somewhat less toxic, although ethylene dichloride and tetrachlorethane are much more toxic. I have reported elsewhere an example of ethylene dichloride intoxication.[4]

Benzene

An older and much more dangerous solvent is benzene. This we will probably have to use more and more since war priorities absorb its safer substitutes such as toluene. Benzene is an excellent solvent for cellulose lacquers, rubber cement, paint remover, and floor wax. It is a poison in every sense of the word, although it, too, can be used safely with modern protective engineering devices if its danger is frankly faced. Its portal of entry is both by the skin and inhalation through the nose and its point of attack is primarily in the bone marrow, upon the blood-forming system both upon the red and the white cell series.[5]

Knowing that there has been exposure to the solvent, benzene, one expects impending intoxication when the patients complain of tiring easily, weakness, loss of appetite, nausea and headache, and particularly when they complain of nosebleed or uterine hemorrhage. Also, if on physical examination one finds bleeding gums and evidence of purpuric spots combined with laboratory findings with no clot retraction and a thrombopenia together with anemia, definitely under 4,000,000 and leukopenia with white cells under 5,000, one is definitely inclined to make a diagnosis of benzene poisoning. Aplastic anemia usually develops with this true benzene poisoning, so that if one waits for a definite case of benzene poisoning, one is likely to be confronted by a hopeless prognosis fully as terrible as that of radium poisoning. With benzene exposure, therefore, one should never wait for the advanced and easily diagnosed picture of actual poisoning but should look for early evidences of excessive absorption, such as can be safely gauged by the benzene urinary sulfate test as well as looking in the blood studies for slight tendencies to thrombopenia, anemia, and leukopenia.[6]

A patient who shows evidence of benzene poisoning, even in the slightest degree, should be removed from further exposure and should be protected from intercurrent infection, especially as these individuals seem to lose the ability to fight infection for several months to come even after their benzene anemia has improved.

It can easily be seen that the manufacturer should consider the use of these toxic substances and solvents only after carefully consulting with his physician as to the possible effect upon the health of the worker following their use. Because these poisons act upon internal organs such as the liver, kidneys, and heart, as well as upon the blood-forming system, the same refined and complicated organ-function tests must be used in their study as those the physician uses in his private practice, studying Bright's disease, cirrhosis or anemia. Just as in the case of lead, the example of the toxic dust, so with chlorinated solvents and benzene, examples of the toxic solvents, the prime factor must be one of medical control.

Toxic Gas

The third toxic substance to which the worker is exposed in industry and in war is the toxic gas. We learned much about this in the last war, and when the Axis powers are driven to desperation, we may learn much more about toxic gas in this war. In industry, we of course have exposure to chlorine and the various acid vapors in pickling work. Contrasting war experience, these exposures in industry have more of a nuisance value than of any danger to life or health. It is not generally realized, however, how much the average worker is exposed to a much more toxic gas, namely, the oxides of nitrogen. This is developed in the bright dipping of brass previous to plating, in welding in enclosed spaces, or even in using the oxyacetylene torch in poorly ventilated rooms. Nitric oxide is found in the manufacture of toluene and in the making of explosives, also in tunnels where blasting is done. It enters the body by inhalation, and the point of attack is primarily at the portal of entry, namely, the lungs. Unfortunately, there is usually no marked immediate bronchial irritation, as there is in the case of chlorine, because the oxide of nitrogen victim does not seek immediate escape from exposure as does the chlorine exposed patient.

Several hours later, usually six to eight hours after exposure to the inhalation of oxides of nitrogen, the patient develops shortness of breath, and he drowns in the outpouring of fluid in his lungs. This pulmonary edema is such as is seen with the war gas phosgene. If the physician is not alert enough to inquire as to the occupation of the patient to whom he may be called upon in the middle of the night as an emergency case, he is likely to make the diagnosis of acute heart failure or pneumonia. The emergency treatment is, of course, the administration of oxygen with a catheter placed in both nostrils and an attempt to decongest the lung by giving hypertonic glucose in the form of 100 cc. of 50 per cent glucose together with an ampule of salyrgan.[7]

Carbon Monoxide

Another example of a toxic gas is the asphyxiant carbon monoxide. This occurs almost as frequently in industry as lead. It occurs wherever there is incomplete combustion as when a flame touches a cool metal surface, and it is, of course, actually used in certain processes such as blast furnaces and occurs as a by-product in the making of water gas. Carbon monoxide absorption is much more dangerous than lead absorption. It, too, is taken into the body by inhalation. However, its point of attack is not at the portal of entry but deep in the tissues, where by reduction of the oxygen supply it causes local asphyxia.

The first symptoms are tightness across the forehead, slight headache, throbbing of the temples and dimness of vision.[8] To confirm a clinical impression of carbon monoxide absorption, one should obtain a blood sample promptly, if possible, because within two to four hours, 50 per cent of the carbon monoxide may be eliminated if the patient is breathing normally. Every physician can draw the blood sample of 5 cc. of venous blood. This should be taken in an oxalated test tube and studied in an appropriate laboratory by the pyrotannic method of Sayres and Yant. Upon discovering a nondisabling level of carbon monoxide absorption, the industrial exposure can be rechecked and the borderline concentration reduced before workers are submitted to overwhelming carbon monoxide intoxication. Small blood concentrations of 5 to 15 per cent are negligible because carbon monoxide is not cumulative in action, and, further, such blood percentages may often be caused by smoking cigarettes. For diagnosis one must not wait until the patient shows the typical so-called cherry-colored skin and mental confusion or unconsciousness coming on after weakness of extremities. If we do wait until these advanced symptoms are manifest, we may have either death or, rarely, serious residuals from the central nervous system asphyxia, such as violent attacks of recurrent pain or convulsions.

Physician's Responsibility

As physicians, our responsibility is not only to diagnose and treat the poisonings in

industry, but we must also advise industrial commissions, employer, and worker whether there has been permanent damage from poison absorption and, if so, how much in actual percentage. This is not as simple as estimating the percentage range of motion loss due to an amputation. It involves the detailed study of the functional reserve of the heart, liver, and kidneys.

Even though a physician does not limit his practice to industrial medicine, he will be much better able to keep his fellow men working in the war effort if he remembers to ask himself these questions: What is the occupation of my patient? Is this a case of acute abdominal pain, appendicitis, or lead poisoning? Is this acute pulmonary edema due to heart failure, or is it an oxide of nitrogen intoxication? Is this severe anemia, pernicious anemia, or is it benzene poisoning? Is this a case of jaundice or acute Bright's disease, ethylene dichloride or carbon tetrachloride poisoning?

As long as we have industry, we physicians must be informed as to the poisons of industry. We must be familiar with the technics and hazards of industry so that we may be forewarned. We must mingle with the worker and the engineer in their work places if we are to prevent the suffering and disability which may well prolong the war. We must remember that here, as in the practice of general medicine, we are dealing with the art of medicine and that there is no single step with which we can shortcut our study of the whole picture of disease. Our opinion must rest upon (1) appraisal of exposure of the worker to a possible poisoning, (2) a review of characteristic symptoms, (3) an analysis of our objective physical and laboratory studies, (4) correlation of the above with our own observation of the patient at work in his factory work place, (5) a survey of the readily available knowledge of the accumulated experience of the entire profession on this subject of poisons in industry, and (6) an accurate diagnosis and intelligent prescription with a minimum of complicated procedures when time, equipment, and the individual worker are precious and irreplaceable, now more than ever before at this particular moment of history.

BIBLIOGRAPHY

1. Kehoe, R. A.: Lead absorption and lead poisoning, Med. Cl. N. Amer. 26:1261 (July) 1942.
2. Belknap, E. L.: Lead poisoning—criteria for diagnosis, Indust. Med. 9:505 (Oct.) 1940.
3. Belknap, E. L.: Control of lead poisoning in the worker, J.A.M.A. 104:205 (Jan. 19) 1935.
4. Belknap, E. L.: Common poisons in industry, Pub. Health Nursing 30:465 (Aug.) 1938.
5. Hamilton, Alice: Benzene (benzol) poisoning, Arch. Path. 11:434 (Mar.) 1931.
6. Schrenk, H. H.; Yant, W. P., and Sayres, R. R.: New procedure for control of benzene exposure (urine sulfate test), J. A. M. A. 107:849 (Sept. 12) 1936.
7. McNally, W. D.: Nitric oxide fumes, Indust. Med. 11:207 (May) 1942.
8. Henderson, Yandell: Adventures in Respiration, Baltimore, Williams & Wilkins Co., 1938, p. 111.

SCIENTIFIC EXHIBITS—A. M. A.

The Scientific Exhibit at the Chicago Session of the American Medical Association, June 12 to 16, 1944, will be held at the Palmer House. Exhibits will cover all phases of medicine and the medical sciences with particular emphasis on graduate medical instruction for the physician in general practice.

Application blanks for space in the Scientific Exhibit are now available and may be obtained by communicating with the Director, Scientific Exhibit, American Medical Association, 535 N. Dearborn Street, Chicago 10, Illinois.

Comments on Treatment

Editors—A. J. QUICK, M. D., Marquette University, Milwaukee, and
A. L. TATUM, M. D., University of Wisconsin, Madison

Malaria

Although many warnings have been appearing in recent medical literature concerning malaria and its liabilities in states ordinarily considered nonmalarious, a few additional notes may well be timely.

The writer recently had the privilege of seeing malaria in many of its multitude of manifestations as well as its response to therapy. One of the outstanding peculiarities of this disease is the plurality of its manifestations, including disturbances in practically any or all of the organs and tissues of the body. Thus, there appear coma, neuritis, nephritis, "appendicitis," liver and gallbladder symptoms, blood dyscrasia, and cardiovascular disturbances. Somewhat like syphilis, it imitates many diseases. The statement was made to the writer that many an appendix was surgically removed when, instead, a course of antimalarial drugs would have sufficed.

Malaria cannot be cured by any known means. Patients may be eased over into a state of latency, i.e., malaria without symptoms, but subject to the possibility, or even likelihood, of relapse whenever the resistance of the host is so reduced as to allow a recurrence of the active phase of the disease. Antimalarial drugs must be considered as suppressive rather than curative. Furthermore, there is no effective prophylaxis other than avoidance of infective mosquitoes. Drugs used "prophylactically" may prevent acute manifestations, but they do not assure against latency. The implications, therefore, are obvious.

A question frequently asked is whether or not atabrine (quinacrine, U.S.P. XII) is as effective and as safe as quinine. At the present time, one must conclude that atabrine, a synthetic preparation, is essentially as effective as quinine. But the "lay" statements to the effect that it cures and is without harm cannot be supported. Experimentally and clinically, both drugs are inherently capable of leading to disappointment as well as being likely to produce undesirable reactions. Reduced tolerance to low oxygen concentrations is readily demonstrable experimentally, and men flying at high altitudes, while receiving atabrine, have been subject to unfortunate consequences due to this drug.

Quinine, for its part, is capable of producing nerve injury and other side actions, a fact that has been recognized for a very long time. Whether or not totaquine, (U.S.P. XII), made up of the total alkaloids of cinchona, will be as prone to produce undesirable side actions as is quinine remains to be determined.

Practically, atabrine, quinine or totaquine must be given for malaria. Plasmochin, reputedly effective in ridding the body of gametocytes, is a hemolytic drug and, therefore, rather undesirable. Gametocytes, after all, arise from schizogony and do not reproduce themselves in man. Repression of schizogony, then, includes repression of the development of gametocytes. The trend now is to strike at malaria with atabrine or quinine and generally to omit the plasmochin.
—A. L. T.

COMMITTEE OF ONE

Your State Society has prepared loan packets on the Wagner–Murray–Dingell Bill for those of the Society who may wish material for local purposes. The packet contains a copy of the bill, comments and analyses from various sources concerning it, a copy of the Beveridge report and other pertinent material. A limited number are now available, and others will be made up should the demand warrant. Address your requests to the State Medical Society, giving the date by which the material is required.

The Nation at War

In this section of *The Journal*, to appear monthly for the "duration," there appears pertinent information relative to the activities of the medical profession in serving its country in this time of trial. Members are urged to consult this section regularly henceforth.

Instruction of Civilian Physicians in Gas Warfare

By J. A. E. EYSTER, M. D.
University of Wisconsin Medical School
Madison

Wisconsin Gas Warfare Faculty holds a "post" on the course held in Fond du Lac on October 12, 13 and 14 at St. Agnes Hospital. Left to right: M. Starr Nichols, M. D., State Laboratory of Hygiene, Madison; K. K. Borsack, M. D., Fond du Lac, County Chief of Emergency Medical Service; Mr. Nelson, Fond du Lac, County Council of Defense; J. A. E. Eyster, M. D., Department of Physiology, University of Wisconsin Medical School; and A. R. Curreri, M. D., Department of Surgery, University of Wisconsin Medical School.

UNDER the auspices of the Wisconsin Council of Defense and the State Medical Society of Wisconsin, courses for civilian physicians in the Medical Aspects of Gas Warfare have recently been given in a number of Wisconsin communities. The reaction to these courses on the part of the physicians has in general been favorable, but questions have arisen as to the necessity or even the desirability of expending time and effort on preparation for the possibility of an attack from the enemy during which the civilian population will be exposed to toxic gases. It has seemed to me, as a participant in one group of these courses, that the various criticisms and doubts have crystallized into two major questions, which I will now state and attempt to answer.

Why the Emphasis on Gas?

If gas is used against the civilian population of this country, it will certainly be by way of an airplane attack. It is also highly probable that it will not be used alone but along with high explosive and incendiary bombs. Under these circumstances, the civilian physician will be called upon to take care of victims with wounds due to bomb or other fragments, with thermal burns and with lesions due to poison gas. By training and experience he will be able effectively to care for the first two types of injuries. In the majority of instances, however, he has none or little knowledge of what to expect or what to do with the third class of injuries, those due to the action of poisonous chemicals used in gas warfare.

Will Our Civilian Population Be Exposed to Raids From the Air?

It is obvious that an unequivocal yes or no answer cannot be given to this question. World conditions and human relations and conduct have changed so greatly that it is difficult to adjust our thinking to meet them. Declaration of war, treaties and official and solemn pronouncements and promises by governments have become farcical. Surprises, stabs in the back, the production of false situations, propaganda to promulgate a feeling of false security are all the order of the present day. Principles of honor and chivalry are at the present time conspicuous only by their absence. If they were dying before, they received their death blow on Sunday, December 7, 1941, at Pearl Harbor. Attacks at the most unexpected places, in the most unexpected manner, and at the most unexpected time, upon civilians, civilian

and military property as well as on armed forces have become firmly established as means in modern warfare. Treaties, peace agreements and even pacts of mutual aid and assistance between governments are no longer to be regarded as insurance in any degree against disastrous attacks or valid articles to allow the illusion of peaceful security into which our people are so particularly prone to drift. The solemn pronouncement of a great American, "In time of peace prepare for war," has been forgotten or ignored in our times, and its forgetting and its replacement by "It can't happen here" has led us closer to the abyss of destruction than our nation has ever come.

Many of our profession are in the armed forces, and to those of us who are left, the proper medical care of our fellow civilians has demanded a degree of effort unknown before. It is difficult for us to increase this burden by taking time to consider anything which has previously been outside our mental vision, and which by many may be considered of minor importance at the present time. On the other hand, if by any chance we are forced to face a medical disaster to which we have given no previous thought and for which we are totally unprepared, we have failed dismally in our duty to ourselves and to those who depend upon us. The fact that we are at war, on the one hand, or the feeling of security from the enemy which we may have in this region, on the other hand, should receive no consideration for or against our preparation for a disaster which may come upon us at any time in war or in peace.

The Bruns General Hospital

"The Bruns General Hospital, which was formally dedicated on September 22, is located in Santa Fe, N. M. The hospital was activated on February 18 and the formal flag raising was celebrated April 19, at which time the first patient was admitted. Although the hospital was built with a thousand bed capacity, recent construction will soon afford 1,500 beds. It is of cantonment type composed of open and closed wards, officers' and nurses' quarters, barracks, utility shops, warehouses and a chapel. All the wards, quarters and barracks are connected by either closed or covered walks.

"The Bruns General Hospital was named in honor of the late Col. Earl Harvey Bruns, who was recognized as one of the world's leading authorities on pulmonary tuberculosis. The hospital has not been designated as one for any particular specialty, but rather a typical general hospital. It is equipped to care for surgical, medical, eye, ear, nose and throat, genitourinary and neurologic and psychiatric cases."

Among the medical officers assigned to the Bruns General Hospital as of September 27 are the following Wisconsin physicians:

Surgical Service

Major Marshall W. Alcorn, M. C., assistant chief, of Burlington, Wis.

1st Lieut. Robert R. VanDenmark, M. C., Stoughton, Wis.

Medical Service

1st Lieut. Clifford H. Kalb, M. C., Grafton, Wis.

Eye, Ear, Nose and Throat

Capt. Earl W. Martens, M. C., Milwaukee.

—From the November 6, 1943, issue of *The Journal of the American Medical Association.*

Military Notes

Lieutenant Commander Thomas A. Leonard, USNR, formerly of Madison, writes the following letter to the secretary's office from the U. S. Naval Hospital, Oakland, California.

"Dear Charles:

"Had a wonderful trip out through the west. This was my first vacation in a long time, and perhaps for this reason it was especially enjoyable. We visited most of the interesting places along the way without burning up too much unnecessary gas. Lake Tahoe area I liked particularly.

"I once again find the Navy a mighty fine place, and the excellence of the work done in this hospital is not to be questioned. I have been able to fit into my responsibilities here well, and feel that I am becoming a little more useful each day.

"Our hospital is very well equipped, and the Corpsmen are wonderful surgical assistants. This is very serious business here—and we all work hard at it—but also have a little time to ourselves.

"So far I am a dry land sailor, but one never knows how long this will last.

"Our hospital is beautifully located, and I drive two miles up Mountain Blvd. each morning to reach it. It has been erected on the site of a former golf course and has grown tremendously in the fourteen months of its existence.

"Can you send *The Wisconsin Medical Journal* to me here, please? If my paper is published this month, may I have a copy of it, as I would like to present it at one of our staff meetings here?

"My very best wishes to all of you and thanks much for your many kindnesses of the past."

Commander James C. Sargent, USNR, Milwaukee, a past-president of The State Medical Society of Wisconsin, has been transferred to the U. S. Naval Hospital at Shoemaker, California, as chief of urologic service. Dr. Sargent's family has moved temporarily to Palo Alto, California.

A recent appointee to the surgical staff of the McIntyre Hospital at the Great Lakes Naval Training Station is **Lieutenant Commander Nathan E. Bear**, son of Dr. and Mrs. W. G. Bear of Monroe. In August, 1942, Dr. Bear was assigned to a naval air base off the South American coast but was forced to return to the States after a recent severe illness. Dr. Bear is a former member of the Monroe Clinic.

Dr. Robert W. Shaw, Marinette, who recently has been discharged from army service, spoke to the Marinette Kiwanis Club at its October meeting on his experiences in the Army Medical Corps, in which he held the rank of captain. Dr. Shaw was in service a year, first acting as battalion surgeon at Camp Shelby, Mississippi, for five months. From Mississippi, Dr. Shaw was transferred to the east coast, where his group checked the physical condition of German and Italian war prisoners. He told the Kiwanis group that the low mortality rate of American soldiers is due to better equipment, food, and to a better organized medical department.

The eighth staff member of the Quisling Clinic, Madison, to enter the service is **Dr. Rolf A. Quisling**, ear, nose and throat specialist. Dr. Quisling, who has been on the clinic staff since 1932, has been commissioned a lieutenant in the Navy and reported Monday, November 8, at Memphis, Tennessee, for active duty. Lieutenant Quisling is a member of the American Board of Otolaryngology. The lieutenant has a twin brother, **Captain Gunnar Quisling**, who is somewhere in England with the U. S. Army Medical Corps.

Visiting his family and friends at Cudahy during the last week in October was **Captain Jacob M. Fine**, former physician and surgeon of that city. Having been in the Battle of Attu, Captain Fine, who has been with the U. S. armed forces for the last year, has seen a great deal of action in the present world conflict.

Lieutenant Harold L. Baxter, former physician and surgeon at Waupaca and Neenah, and who was medical officer on the American light cruiser *Boise*, which saw action in the Solomon Islands area, has returned to the United States. For the next three months, Lieutenant Baxter will be in Philadelphia, where he has been assigned to the U. S. Naval Hospital for a three-months' course in psychiatry. Upon completion of his course at Philadelphia, he will be given shore duty. Mrs. Baxter, the former Anona Terrio of Waupaca, and their daughter have gone to Philadelphia to be with Lieutenant Baxter.

E. M. DRURY

A former New Richmond practitioner, Captain Ernest M. Drury of the Medical Corps of the AUS is officer in charge of the station infirmary and outpatient service at Ellington Field, Texas. In addition, he is post medical inspector at the huge twin-engine advanced flying and preflight bombardier-navigator school near Houston. Captain Drury is a graduate of the University of Wisconsin Medical School.

At the October meeting of the Waukesha Lions Club, **Major Everette L. Lochen**, former physician of that city, who is now a surgeon in the Army Medical Corps, related many of his experiences during Japan's surprise attack on Pearl Harbor. Major Lochen, an officer in the reserve corps prior to his enlistment in 1940, spent six months at Chanute Field, Illinois, before sailing to Hawaii. Passengers on the trip included twenty-two medical officers, bound for Manila, to whom Major Lochen gave lectures each day. He said not one of these doctors has returned from the Philippines.

Upon arriving in Hawaii, Major Lochen was assigned to Tripler Hospital at Honolulu as registrar. A short while later came the attack on Pearl Harbor. Major Lochen spent the next four days in surgery. He stated that the thing which most impressed him was the fact that none of the patients were hysterical, or even whimpered, in spite of the ordeal which they had gone through. Major Lochen also said that machine gun bullets were constantly flying around the hospital, and several times doctors were almost hit. Amputations were performed on wounded soldiers on the hallway floor of the hospital, without nurses' help, rubber gloves, and the other necessities of surgery.

The Nisei in Hawaii, according to Major Lochen, appeared to hate the Japs intensely and have supported every government policy. He said that while the Army asked for enough Nisei recruits to form one regiment, enough responded for five. Thus, three were organized and some of them are now with the Fifth Army in Italy.

One interesting feature brought out by Major Lochen is how the people in Hawaii take the Japanese living there for granted. There is no such thing as segregation, as we have on our west coast. The Japs, he said, are doing essential war jobs. Apparently, their transportation to the mainland would be too great a job, according to Major Lochen.

Returning to the mainland, Major Lochen was sent to Seattle, expecting to be assigned to the Walla Walla, Washington, hospital. Thus, his and Mrs. Lochen's baggage was routed there. Then the Army changed his plans, and he was sent to Spokane. Major Lochen said they haven't seen any of their luggage since.

Word has come to *The Journal* that Dr. Robert S. Baldwin, Marshfield, who was called late in 1940 to active service in the Army Medical Corps with the rank of captain, and who was promoted to major in Australia a year ago, is now a lieutenant colonel. Dr. Baldwin's new assignment is in New Guinea. This information comes from his former associates at the Marshfield Clinic. Colonel Baldwin's wife is living in Highland Park, Illinois, at the present time.

Dr. John H. Wishart, Eau Claire, left Friday, November 2, to report for duty as a lieutenant (jg) at the U. S. Naval Hospital, Oakland, California. Lieutenant Wishart will hold the rank of assistant surgeon. Dr. Wishart has been medical director at the Eau Claire Ordnance plant since it was started, and previous to that time was associated with the Midelfart Clinic at Eau Claire. Mrs. Wishart will accompany the doctor to Oakland.

Wisconsin Physicians in Service—Recent Appointments*

Dane County
Quisling, R. A., Madison

Eau Claire County
Wishart, J. H., Eau Claire

Fond du Lac County
Reslock, C. P., Waupun

Jefferson County
Schoenecker, E. A., Lake Mills

Milwaukee County
DeCock, R. D., Milwaukee
Dunst, C. G., Milwaukee
Fifrick, L. L., Milwaukee
Prout, F. J., Milwaukee
Schelble, J. P., Milwaukee
Schwei, G. P., West Milwaukee
Smits, R. H., Milwaukee

Portage County
Sowka, P. N., Stevens Point

Sauk County
Randall, E. M., Prairie du Sac

Sheboygan County
Hansen, H. L., Sheboygan Falls

Winnebago County
O'Brien, P. T., Menasha

* October 1 to November 16, 1943.

IMPORTANT REMINDER

The bill calling for annual registration of physicians became a law of the State of Wisconsin on May 17, 1943. It states that "Every person licensed to and engaged in the practice of medicine and surgery, osteopathy, or osteopathy and surgery, in this state, shall, in the month of January of each year, register with the secretary of the Wisconsin state board of medical examiners, upon a form to be furnished by the board."

By this time you probably have received the simple registration form from the secretary of the State Board of Medical Examiners. The fee for 1943 is $3.

Although the law states that the form must be returned during the month of January, do not put it off. Give it your immediate attention and aid in the prompt and effective administration of the annual registration law, sponsored and endorsed by the State Medical Society of Wisconsin, because:

1. It provides the only means by which a current and correct inventory of physicians in Wisconsin can be maintained.
2. Such an inventory will be of immeasurable value in assisting in the proper distribution of physicians, particularly as this problem becomes acute at the conclusion of the war.
3. By annual publication of a list of physicians, every law enforcement officer in the State of Wisconsin will know who is licensed to practice, and is practicing, in this state.
4. For the first time it will provide the State Board of Medical Examiners with a sum sufficient to enforce the Medical Practice Act and thus secure the elimination of the unlicensed quack and charlatan.
5. It has proven a highly satisfactory public health law in twenty-three states in which it is now operative.

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« « « EDITORIALS » » »

"The Curse of Bigness"

WHEN bill 327, A., introduced by Assemblyman Charles Westfahl of Milwaukee and proposing to create a system of health insurance in the State of Wisconsin, was heard before the Assembly Committee on Public Welfare in 1943, Elizabeth Brandeis, representing the Wisconsin Welfare Council, expressed her belief that "some provision is coming, and I feel very strongly, because it is up to the states to take action if they are to preserve state government, and to have the state functioning in these important fields rather than for such things to be operated from Washington. I think that even the State Medical Society, which has been afraid of government action in this field, will agree that they would rather have action on the state level than have action on the national level, so that the program will be one for Wisconsin and not one for the nation."

This was a new approach. It begged the question. It tended to focus the argument on the respective merits of a state system as opposed to a national system and tended to avoid an issue based on the merits of the proposal itself. It might be influenced by the fact that under the Wisconsin proposal, under which 2,000,000 people would have been covered, an administrative system embracing possibly from 20,000 to 25,000 employes would be required.

But it is easy, apparently, for state officials to become nationalized in their views. There has been something of a burning controversy between representatives of the Wisconsin Unemployment Compensation Department and those of the Federal Social Security Board over the question of whether unemployment compensation should not be federalized. Arthur J. Altmeyer, onetime secretary of the Industrial Commission of the State of Wisconsin, and now chairman of the Social Security Board, finds himself one of the principals in the controversy as a result of his change in position. In articles appearing in the *National Municipal Review*, May, 1943, and September, 1943, the proponents and opponents

of federalized unemployment insurance are revealed in the persons of Mr. Altmeyer and Mr. Paul A. Raushenbush of the Wisconsin Unemployment Compensation Department and president of the Interstate Conference of Employment Security Agencies.

According to Mr. Raushenbush, Mr. Altmeyer has reversed his field. In 1940, he is quoted as praising state administration and saying that "all states . . . are solving the administrative problems involved with a high degree of success," which appeared consistent with his remarks in 1938 in which he is quoted as telling state administrators, "The Board is of the opinion that a national system would have broken down under the initial impact of the administrative difficulties which you have been able to surmount with such a considerable degree of success."

But now Mr. Altmeyer finds substantial reasons for federalizing this administration. Because the "cost of social insurance is related to payrolls" says the former Wisconsin executive, "it is important that employers not be subjected to unfair interstate competition because of varying rates of contributions in the various states." Thus he argues for federalization because unemployment compensation eligibility for benefits and the rate and duration of benefits vary sufficiently so that a worker may be ineligible in one state though he would have been eligible in another. According to Mr. Raushenbush, Mr. Altmeyer fears the security of the reserves in some states, although he fails to specify which states, and expresses concern over the number of workers moving between states—migratory workers—who will fail to secure protection because of the instability of residence.

"Nationwide Forces on a National Basis"

Mr. Altmeyer is particularly desirous that the matter "not be viewed as an abstract question of states' rights or of federal administration versus state administration," and emphasizes that it is essential to perfection of the system that risks be pooled so that the "nationwide forces" causing unemployment can be met "on a national basis." According to Mr. Raushenbush, Mr. Altmeyer is convinced that there would be distinct advantages that would follow from maintaining one set of government "record keeping" and necessary reports against the individual sets that must now be maintained by the various states.

But Mr. Raushenbush has an answer for every important point made by Mr. Altmeyer. He makes the rather pertinent comment that these current efforts to federalize unemployment compensation doubtless are "closely tied in with current plans for a completely national system of social insurance, with state and local participation in the whole broad field of social security confined to a narrow vestige in public assistance matters." Mr. Raushenbush believes it is time to consider whether state action should not be taken to extend social security into the new fields of sickness, hospitalization, and so-called "health" insurance, and points out that if the national government "were to succeed in taking over the entire field of social security, a tremendous stride would have been taken toward centralized control over the daily lives of most citizens."

He maintains that it is "vital for a democracy to maintain effective participation in government affairs by ordinary citizens, and therefore to preserve municipal and state functioning wherever practicable. For the country is too big, and Washington is too remote, for ordinary citizens to participate effectively in any 'uniform national system,' even though it closely affects their daily lives."

"Progress Rather Than Perfection"

As to some of Mr. Altmeyer's specific complaints, Mr. Raushenbush provides interesting and provocative answers. He states that as to alleged inadequacy of benefits, Mr. Altmeyer himself "has often recognized that social legislation can never be considered complete or final. Its test is progress rather than perfection."

So, says Mr. Raushenbush, states have steadily progressed toward liberalization of waiting periods, weekly benefit payments and their duration, as well as coverage, the latter having developed further "than the national law which implements them." As to the migratory workers, Mr. Raushenbush says that "workers who build up substantial benefit rights in one state and then move to another do not lose those rights. They can claim through the state they're in under a cooperative interstate plan which has worked smoothly for several years." And taking on Mr. Altmeyer's convictions as to the possibility of higher benefit levels under a national law, Mr. Raushenbush strikes a body blow with the pertinent inquiry as to how advocates of federalization can be sure that national benefits "*would be much above those now provided by the more liberal state laws? Even big promises have to be paid for. Isn't Congress likely to count the costs and to consider the probable impact of benefit levels on industrial operations?*"

Mr. Raushenbush feels that state organizations may be a good deal more flexible than a big national one and thus better able to cope with the heavy impact of postwar layoffs. He argues that "there will always be a deal of truth in the Brandeis phrase 'the curse of bigness' and in its thesis that smaller units are often more efficient than big ones—in government as well as in business."

But the criticism that one makes of another is pertinent to current proposals of extending these programs into the field of care of the sick. Many of the arguments made by both Mr. Raushenbush and Mr. Altmeyer, together with many another, are a part of the basic criticism in the thesis of the medical profession that you cannot harness personal services into a regime of governmental benefits for one and all and maintain the health achievements of this nation.

All these difficulties which are cited by Mr. Raushenbush and Mr. Altmeyer are difficult ones; yet in their arguments pro and con, both are dealing with *cash benefits* readily measurable by the recipient and not with *service benefits* of a character that affects the very life of the recipient or his family.

Mr. Altmeyer and Mr. Raushenbush are involved in an interesting argument—and they are deeply concerned over the implications of many of the points of each. Will it happen that the "curse of bigness," state or national, becomes a bugaboo in the delivery of good medical care? We hope not.

1944 Dues—Donation or Investment

MEMBERS of the State Medical Society of Wisconsin will pay dues of $33 for the calendar year of 1944. The reference committee of the House of Delegates which proposed dues in this amount stated to the House that this action was needed because "the medical profession is confronted with problems with reference to the pending proposals for the change of the economic system under which the individual physician would be able to engage in practice, and particularly the need for the further and wider dissemination on the state level of information to the public concerning these vital projects" and the need that exists "to protect the integrity of the medical profession for the men in service as well as those who remain on the home front, because of the probability that confronts the organized medical profession that the war effort will demand the enrolment of a greater number of physicians than are represented in the armed services at the present time."

When members of the Society appreciate that there are now in excess of 800 Wisconsin physicians in military service, that the problems of the times are complex and of a variety never before encountered, and that the services of the Society to the public health of the people of this state are almost limitless, it does not seem that there will be many who will raise the question of whether dues are a donation or an investment.

. . . . THE PRESIDENT'S PAGE . . . .

STRAWS in the wind are omnipresent and for those who would to interpret. On a recent trip through many large eastern clinics and upon contacting innumerable physicians, a colleague and I, as visiting physicians from the Mid-west, were struck by the interest in medical economics prevalent at the level of the Chiefs of Service as well as at the level of the assistants and residents. Universally they express concern for the future. All seem to be aware of forces taking shape and gaining momentum that would in the postwar period make the practice as we know it only a memory. Quite generally, there is dissatisfaction with what seems the lack of evidence of attempt at solution and direction coming from organized medicine, and there is the feeling that our bulwarks are becoming vulnerable because of such lack of official attention.

The Council on Medical Service and Public Relations, if permitted to explore and study the problem unhampered by those who would use bogeymen and view with alarm every departure from their concepts, will unquestionably do much to negate this assumption.

There can be no liberty under any discipline except that which is self imposed. State-imposed disciplines are, except to enforce moral laws, universally disliked and called fascism. However, any group subscribing to liberty and yet attempting to maintain a majority which has no discipline of itself is destined soon to be without freedom. Asceticisms are essential to survival of every living object or group.

The above, lifted from the context of a recent book that should be, but, American reading habits being what they are, never could be, a best seller, struck me as being apropos of the position of medicine in this country today.

We do, of course, pay lip service to the Hippocratic oath and principles of practice. But have we maintained disciplines that can forestall those that are state imposed and which would constitute the greatest calamity to medicine and, I believe, to the public?

What is needed, and promptly, is a true evaluation of debits and credits in our ledger to determine how gains have been made and greater ones may be achieved. It appears likely that the distribution and accessibility of medical care will prove to be the most fruitful source of gain. It would seem also that the commercialism so prominently displayed in medical practice by some physicians should be sharply curbed. Numerous other disciplines present themselves after mature cogitation.

It would seem further to be desirable to work out a system in urban and rural communities for diagnostic studies at nominal cost. Such a service would make highly technical medicine available to the masses and reduce the cost of medical care by accurate, well directed therapy. The cost in terms of loss to industry, agriculture and society of prolonged illness or lowered efficiency engendered by psychic or somatic illness would likewise be reduced. The practice of medicine would become more attractive to physicians in communities thus equipped because better medicine could be practiced.

Our profession and the public are vitally interested in trends which at present appear to brook evil consequences to medical practice. If medical leadership was ever needed, today is the time for its ascension.

It is advisable, I believe, to convene interested factions of society, labor, capital, farmers and merchants, sociologists, economists and medical men for conference in the broad fields of medical care to establish the need of and the pattern for a more effective utilization of medical facilities, human and physical.

Medicine would be doing society a great injustice were it to leave solution of this problem to any agency, governmental or private, not equipped as are we through a century of organization and experience. Public health is too important a factor in our domestic economy to let recede or not to bring to even greater levels of achievement by not accepting any reasonable challenge for improvement.

THE WOMAN'S AUXILIARY

(ORGANIZED 1929)

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Mrs. C. N. Neupert, Madison
Circulation of Bulletin (special committee)—
Mrs. J. C. Fox, La Crosse
War Participation (special committee)—
Mrs. A. J. McCarey, Green Bay

Christmas Greetings to All Auxiliary Members

It will not be a Merry Christmas for many of us who are separated from our loved ones for the first time. But let us hope that the New Year will bring peace to this wartorn world, that our families will be united once more and on the way back to our happy and normal way of living.

MRS. H. E. TWOHIG
President

County Auxiliary Proceedings

Dane

A dessert meeting of the Woman's Auxiliary to the Dane County Medical Society was held at the home of Mrs. A. R. Curreri, Shorewood Hills, on November 9. Hostesses were Mmes. J. A. Hurlbut, C. K. Schubert and C. N. Neupert.

The October meeting of this auxiliary was held on October 12 at the home of Mrs. Sverre Quisling, Madison. Mrs. Quisling was assisted by her sisters-in-law, Mrs. A. A. Quisling and Mrs. R. A. Quisling.

Dodge

Plans for sending Christmas gifts to physicians in service in the United States were concluded at the business session of the Dodge County Auxiliary held at the home of Mrs. G. H. C. Hoyer of Beaver Dam on October 21. Packages have already been shipped to physicians overseas.

Refreshments were later served by the hostess, and musical entertainment was provided by Miss Margaret Hoyer.

Fond du Lac

Members of the Woman's Auxiliary to the Fond du Lac County Medical Society met for dinner on October 28 at the Elks' Club, Fond du Lac. During a brief business session it was voted that Christmas donations be made to the Children's Home and to Truax Field, Madison. The group then went to Library Hall to make surgical dressings.

Kenosha

The Kenosha County Medical Auxiliary met at the home of Mrs. A. L. Mayfield, Kenosha, on November 2. Assisting hostesses were Mrs. A. J. Randall, Miss Eva Randall, Mrs. C. E. Pechous, Dr. Margaret Persch and Mrs. L. T. Kent.

"Rationing and the Black Market" was the subject of an interesting discussion led by Mr. G. C. Gregg, of the Price Division of the OPA. He was assisted by Mr. W. J. Butch, who showed explanatory movies. Mr. Gregg brought out in his talk that housewives are of prime importance in the eradication of the black market and in assisting the government in its price control program.

A Hygeia committee was appointed, and plans for enlarging the distribution of the magazine were discussed. Letters received from Senators Wiley and La Follette in response to written protests of the Wagner–Murray–Dingell bill were read at the meeting.

Refreshments were served later in the evening, with Mrs. F. H. Robinson presiding at the tea table.

La Crosse

The first fall meeting of the La Crosse County Medical Auxiliary was briefly noted in a previous issue of *The Journal.* At this meeting, which took place on October 20, the following committee chairmen were announced:

Program—Mrs. W. E. Bayley
Social—Mrs. E. E. Seedorf
Public Relations—Mrs. Gunnar Gundersen
History and Archives—Mrs. P. T. Walters
Hygeia—Mrs. G. W. Lueck
Telephone—Mrs. George Reay, Onalaska
Press and Publicity—Mrs. E. H. Townsend
Philanthropic—Mrs. R. H. Gray
Membership—Mrs. F. A. Douglas
Flowers—Mrs. P. C. Gatterdam
Bulletin—Mrs. A. H. Gundersen
War Participation—Mrs. D. M. Daley
Guest Hostess—Mrs. H. G. Scheie

Also during the business session, reports of the state convention were given by Mrs. J. C. Fox, president, and Mrs. G. D. Reay, president-elect. Mrs. Gunnar Gundersen discussed the Wagner–Murray–Dingell bill; Mrs. John Newhouse reviewed the book, "Burma Surgeon," and Mrs. A. H. Gundersen spoke on the current issue of *The Bulletin.*

The auxiliary voted to pay the dues of members whose husbands are in service, and also to place ten subscriptions to *Hygeia* in schools, libraries and public institutions.

At the social hour which preceded the meeting the chairman, Mrs. E. E. Seedorf, was assisted by Mmes. J. C. Harmon, S. B. Gundersen, A. H. Gundersen, R. L. Eagan, K. P. Ruppenthal, R. E. Flynn and N. P. Anderson.

Manitowoc

New officers and committee chairmen were announced at a meeting of the Woman's Auxiliary to the Manitowoc County Medical Society which was held in Valders at the home of the new president, Mrs. E. W. Huth, on October 7. They are:

President—Mrs. E. W. Huth, Valders
President-elect—Mrs. R. J. Portman, Manitowoc
Secretary–Treasurer—Mrs. N. A. Bonner, Manitowoc

Committees

Program—Mrs. R. J. Portman, Mrs. W. H. Scherping, Manitowoc
Public Relations—Mrs. R. W. Hammond, Manitowoc; Mrs. A. W. Kozelka, Two Rivers
Press and Publicity—Mrs. T. H. Rees, Mrs. M. P. Andrews, Manitowoc
Hygeia—Mrs. J. W. Steckbauer, Manitowoc
Social—Mrs. H. J. Belson, Mrs. G. M. Hoffman, Manitowoc
Archives—Mrs. F. W. Hammond, Manitowoc
Philanthropic—Mrs. A. J. Shimek, Manitowoc
Constitution—Mrs. T. A. Teitgen, Manitowoc
War Participation—Mrs. L. W. Gregory, Mrs. A. F. Stueck, Manitowoc
Circulation of *Bulletin*—Mrs. E. C. Cary, Reedsville
Telephone—Mrs. A. J. Shimek, Mrs. W. E. Donohue, Mrs. F. E. Turgasen, Manitowoc; Mrs. A. P. Zlatnik, Two Rivers

Fourteen members heard the program chairman, Mrs. Portman, outline plans for the coming year. She also briefly reviewed the book, "Flowering Earth," by Donald Culross Peattie.

Miss Freda Breaker of the Maple Crest Sanatorium and Miss Freda Newman, county nurse, spoke to the group on tuberculosis work which is being done in Manitowoc County.

Husbands of auxiliary members joined their wives late in the afternoon for an outdoor barbecue supper at the Huth home.

Milwaukee

"Mental Disorders in Time of War" was the topic of Dr. Michael Kasak when he addressed members of the Woman's Auxiliary to the Medical Society of Milwaukee County at a luncheon meeting on November 12 at the City Club. Dr. Kasak is medical director of the Milwaukee County Hospital for Mental Disorders.

In the absence of the president, Mrs. F. R. Janney, the meeting was called to order by Mrs. H. A. Heise, vice-president. Mrs. J. D. Owen arranged for Dr. Kasak's talk.

Special meetings of the study group of this auxiliary, conducted by Mrs. E. F. Barta and Mrs. C. D. Partridge, have been announced. The first of the series was held at the Hotel Schroeder on October 25. Committee chairmen who attended heard discussions of the Wagner–Murray–Dingell bill.

Outagamie

Election of officers took place when the Outagamie County Auxiliary had its first meeting of the season on October 21 at the home of Mrs. E. N. Krueger, Appleton. A supper preceded the program and business session. New officers, all from Appleton, are:

President—Mrs. G. W. Carlson
President-elect—Mrs. D. M. Gallaher
Secretary—Mrs. E. F. McGrath
Treasurer—Mrs. C. D. Neidhold

Dr. A. E. Rector of Appleton, spoke to the women on recent medical legislation, and a report of the Milwaukee convention was given by Mrs. Rector and Mrs. Neidhold.

On the supper committee with the hostess, Mrs. Krueger, were Mmes. W. O. Dehne, E. F. Mielke, W. E. Archer, C. D. Neidhold and E. F. McGrath.

Polk

Mrs. J. A. Nicholson of Milltown became president of the Woman's Auxiliary to the Polk County Medical Society at the monthly meeting held on October 21 at the Log Cabin Inn near Webster. Other officers elected are:

President-elect—Mrs. D. A. Maas, Webster.
Secretary—Mrs. H. J. Jeronimus, Osceola.
Treasurer—Mrs. V. C. Kremser, Amery

An interesting report of the convention held in Milwaukee in September was given by Mrs. R. G. Arveson.

Mrs. D. A. Maas was the hostess at this meeting.

Rock

On October 26, members of the Woman's Auxiliary to the Rock County Medical Society elected officers for the year and heard annual reports of committee chairmen. The dinner meeting was held at the Women's Club, Janesville. New officers chosen are:

President—Mrs. F. E. Brinckerhoff, Beloit
President-elect—Mrs. E. C. Hartman, Janesville
Secretary—Mrs. W. T. Clark, Janesville
Treasurer—Mrs. G. S. Metcalf, Janesville

Dr. Jessie P. Allen of Beloit, who was instrumental in organizing the auxiliary thirteen years ago, was reelected to the advisory board.

A comprehensive discussion of the Wagner–Murray–Dingell bill was given later in the evening by Mrs. F. M. Frechette, Janesville.

Sheboygan

Nineteen members and guests of the Woman's Auxiliary to the Sheboygan County Medical Society attended the first meeting of the season held at the home of Mrs. J. J. Boersma on October 5. Mrs. W. W. Van Zanten and Mrs. V. F. Neu of Sheboygan were assisting hostesses.

Work projects for the year were outlined by the president, Mrs. V. F. Neu, and several members were appointed to assist in the recruiting of cadet nurses. Members voted to devote some time and effort to helping the soldiers at the Veteran's Hospital at Wood, and planned Christmas gifts to be sent to the hospital. A new method of handling programs was outlined by Mrs. J. F. Kovacic, chairman, who stated that each month different groups will plan the programs.

Officers who will serve during the new year are:

President—Mrs. V. F. Neu
President-elect—Mrs. J. W. McRoberts
Secretary—Mrs. L. F. Pauly
Treasurer—Mrs. G. J. Hildebrand
Program and Social—Mrs. J. F. Kovacic

After the business meeting, Mrs. A. J. Brickbauer of Plymouth spoke of the convention held in September, and outlined briefly the provisions of the Wagner–Murray–Dingell bill. Concluding the program, Mrs. J. W. McRoberts reviewed the book "Keep Your Powder Dry."

Transactions 1943 Sessions, House of Delegates, State Medical Society of Wisconsin

SUNDAY SESSION

The first session of the House of Delegates was called to order by Speaker Charles Fidler of Milwaukee in the Banquet Room of the Hotel Schroeder in Milwaukee at 5:30 p. m., Sunday, September 12, 1943.

Dr. W. M. Trowbridge, Viroqua, presented the report of the Committee on Credentials, showing registration of fifty-two members of the House and nine councilors, which, upon motion of Dr. E. C. Cary, Reedsville, variously seconded, was accepted as the roll of the session.

At this point in the proceedings, Speaker Fidler read the resolution endorsing *Hygeia*, health magazine published by the American Medical Association.

Speaker Fidler informed the House that the Council had suggested that the House might wish to authorize the appointment of a Committee on Executive Sessions. Should the House do so, it would empower the Speaker to require those submitting resolutions, special committee reports, and similar matters, to state the subject thereof at the time they seek the privilege of the floor. If the Speaker is of the opinion that the matter is properly one for consideration in executive session, the material, without discussion, will be automatically referred to the proper reference committee. The Committee on Executive Sessions will review the matters brought before the House and will determine those which will be brought before the delegates in executive session. Dr. J. F. Smith, Wausau, moved the appoint-

ment of a Committee on Executive Sessions, seconded by Dr. F. A. Douglas, La Crosse; the motion was voted upon and carried unanimously.

Appointment of Reference Committees

The Speaker then announced the appointment of the following reference committees of the House:

Committee on Credentials: Dr. W. M. Trowbridge, Viroqua, chairman; Dr. G. E. Eck, Lake Mills; Dr. O. A. Stiennon, Green Bay.

Committee on Reports of Officers and Standing Committees: Dr. A. M. Christofferson, Waupaca, chairman; Dr. Charles R. Marquardt, Milwaukee; Dr. J. D. Leahy, Park Falls; Dr. J. K. Trumbo, Wausau.

Committee on Resolutions and Amendments to Constitution and By-laws: Dr. K. H. Doege, Marshfield, chairman; Dr. L. O. Simenstad, Osceola; Dr. L. J. Van Hecke, Milwaukee; Dr. J. S. Supernaw, Madison; Dr. A. A. Cantwell, Shawano.

Committee on Executive Sessions: Dr. C. M. Echols, Milwaukee, chairman; Dr. P. R. Minahan, Green Bay; Dr. H. H. Christofferson, Colby.

Following approval of the minutes of the 1942 sessions of the House of Delegates, as printed in *The Wisconsin Medical Journal* for December, 1942, the Speaker presented the following guests of the Society: Dr. George Post, Chicago, president of the Illinois State Medical Society; Dr. Stephen H. Baxter, Minneapolis, president of the Minnesota State Medical Association; Dr. A. W. Adson, Rochester, delegate to the American Medical Association and member of the new Council on Medical Service and Public Relations; Dr. E. N. Jones, St. Paul, president-elect of the Minnesota State Medical Association; Dr. W. L. Burnap, chairman of the council, Minnesota State Medical Association.

Supplementary Reports

Dr. S. E. Gavin, Fond du Lac, as chairman of the Council, presented the supplementary report of the Council to the House at this point in the proceedings, explaining that the reason the Council had suggested the creation of the Committee on Executive Sessions was to eliminate the procedure adhered to in the past of holding most of the meetings of the House of Delegates in executive session. Many of the matters to be considered, the Council felt, could be considered in open session. He advised the House that two committees had recently been appointed, one, the Advisory Committee to the Veterans' Recognition Board, consisting of Dr. Byron Hughes, Winnebago; Dr. Robert Montgomery, Milwaukee; and Dr. A. J. Wiesender, Berlin. The other committee, the Committee on War Records, is composed of Dr. Robert Blumenthal, Milwaukee, chairman; Dr. Alf Gundersen, La Crosse; and Dr. K. K. Borsack, Fond du Lac. He advised that the Council had rejected the advertising of liquor in *The Wisconsin Medical Journal.* Upon the request of Dr. Gavin, Secretary Crownhart read the supplemental report of the Committee on Maternal Health and Child Welfare.

Following the report of Dr. Gavin, the Speaker then called upon the president of the Society, Dr. Russell Kurten, Racine, who addressed the House with respect to his term of office.

Excerpts from Address of President Kurten

In speaking to you this evening, I do so in a dual capacity—that of your president and also your president-elect.

It is, of course, of great regret to all of us that our president, Frank Butler, passed away during the year and could not finish his term of office. He was extremely proud of the honor that you had conferred upon him, and was doing a grand job when death overtook him.

I would like to ask this body to rise for one minute in silent tribute to our president, Frank Butler.

"God never gave rights without corresponding obligations to fulfill" is a theologian's statement heard recently to cover a spiritual contingency not too far removed from the situation of medicine in today's maelstrom of momentous yet conflicting events.

Medicine has not been remiss in meeting its obligations to society in most respects for rights granted, as attested to by our schools, hospitals, research, journals and the summation of these, our health record and achievements. To adopt again the religious motif, we may be as was the Pharisee who before God and man announced his virtues and attributes, and not like the publican who was humble because of his weaknesses. But who is, in these days of superlatives and unilateral ideologies?

We are all familiar with the pattern for our success. But are we equally familiar with the inadequacies of our structure? Now mind you, the inadequacies are of omission rather than commission, and although they have been generations in the making, their acute manifestation came about when the social structure generally suffered from growing pains on its unbalanced ration. We have always made available the best that scientific medicine can offer but not at the command of all economic levels. We have made our sphere in matters of health all inclusive, and yet we have not accepted jurisdiction in distribution when it appeared inadequate. We have taken from society and industry all the fruits of our labor but neglected to feed back disciplines to make our efforts yield their ultimate capacity for service. The equation medical science equalling the economic hazard of sickness requires a third factor to become a true one, that is, adequate distribution.

The field has been tremendous and our tasks arduous. We can honorably be excused for much but not in my opinion for all of our faults. Medical statesmanship has not been acute always to reali-

ties, but most grievous on the debit side of our ledger is, to quote General Rankin, "that we have so long basked in the luxuriating rays of medicine as the apothesis of professions that we have become languid and inelastic in our attitude and hesitant and fearful in our response to existing socio-economic developments." Trends and signs of need were well illuminated even before the depression leveled our house of cards, establishing beyond the shadow of a doubt that the American way was vulnerable unless kept in economic and social balance. Our leaders chose to tempt providence too long, and when legislators began to test medicine's vulnerability, our bulwarks were inadequate and our retreat not orderly or well conceived.

An Earnest Effort to Perform Our Obligations

From my humble vantage point, there appear on the horizon several positive and several negative approaches to our problems, and I would place first the admonition to practitioners of medicine and their chosen leaders, for the time being at least, to disregard the premise of rights and to substitute an earnest effort to perform our obligations on a 360 degree front. This will make mandatory the clearing of the decks for action on the distribution of medical care. Later I will discuss certain principles that I believe are fundamental to the public's and medicine's best interests in this regard.

Secondly, I would put the clearing of the problem of what constitutes medical and what hospital jurisdiction in the delivery of such care. The more one explores the principles for practice as laid down by the American Medical Association and the practice in the field, the more one is led to believe that there is a wide latitude. Even the most sacred of our principles, our code of ethics, leaves much to be desired as it is actually practiced; and physicians, except as their own prerogatives are alienated, have become inured to infractions, and one rarely hears of disciplinary recourse being taken by a society. One would judge from the special bulletin of the Board of Directors of the American Medical Association regarding hospitals practicing medicine that solution is untenable, this only, I might add, because medical men refuse to sacrifice personal advantage in one sector for protection and security of the profession as a whole in another. This field is too fraught with pitfalls to enlarge on it at this time, but its leverage on our problems of today and the future is terrific and will ultimately prove an Achilles' heel to organized medicine in the pressure of Wagner acts, hospital management's grandiose ambitions, and competitive-minded physicians with accountant rather than Aesculapian cerebrums.

Industrial Medicine

Thirdly, I would suggest a more comprehensive practice of industrial medicine. Dr. Draper, the erudite industrial hygienist, and numerous others have pointed out repeatedly the trenchant need for expansion of the interest of practitioners in this field. The development of chemistry and its application in industry, high-speed production methods, shifts, transportation and nutritional problems all mitigate against health unless their potentialities for evil are discovered in every instance; this requires greater specialization and alertness in industrial hygiene by physicians purporting to be interested in that field. It must become an integral part of medical education and its practice as a specialty or major interest encouraged. Each industrial community must be served adequately, medical societies must take cognizance and perfect machinery to implement this accomplishment. An evaluation of the objectives of the society in the field of industrial health is desirable in this light. If they are compatible with our present set-up, fine, if not, modification to the exigency is necessary.

What has this to do with distribution of medical care and positive steps to strengthen medicine's citadel? Our obligation to public health and society dictates a reduction of health hazards and illness incident to uncontrolled controllables to minimize the bill for medical care on the national level. I see this field as an especially fertile one for such curtailment. Numerous others will occur to you and must be similarily approached.

Organized medicine's substitution for government does not alter the principle of coddling our citizenry; rather, it creates a legitimate pattern for future governmental action, blessed by us. The principles of legitimacy as outlined by Fararrio have broad implications. The adoption of a program by practitioners of an art makes the program legitimate in the public domain. For years we have decried the principle as being detrimental to public health and sound medical practice. We should adhere to the principle and seek a sound program to foster before the public, which will encourage thrift and dependence on one's own competence, merely expecting from society an opportunity to indemnify one's security be it in health, fire or windstorm. Only the patient's participation in the load will satisfy this postulate.

Public Affairs and Politics

More cogent, we must as physicians enter into public affairs and politics, using the training and intelligence in human affairs we possess to influence legislators to cut the frills in government, local, state and national, to keep the tax burden on a declining scale permitting Mr. Average Citizen to meet his bodily needs, educate his children and enjoy cultural advantages. I need not elaborate on the burdening of direct and hidden taxes that are scaled to a nuisance level for lower income persons and families. What with the backlog of taxes accumulated in this present war, even those devoid of frills, a real load will exist for generations. On a national level, the system of educating legislators in medical economics and practice, so successful in Wisconsin and Minnesota, must be practiced. Our legislators

will not knowingly sabotage a system as important to internal economy as ours if we will but indicate a way out to meet a need, a way that is honorable and in line with American ideals, individual competence and initiative.

A Program

By custom, the president of this Society each year appears before this body to offer a program for his year of incumbency. I will present some issues crying for clarification and action on the state level. Some of these are exclusively in our domain, in others we are only a potential factor. I make no passionate appeal for their adoption into our program, but I hope they will activate this body to consider them both in committee and on the floor in order that what disposition is made will be definitive and represent a decision of Wisconsin medicine.

An awareness of altered circumstances in the American way of life is beginning to take root. What our foreign policy will be and the extent of our commitments both material and financial to whatever the policy may be remains for Congress to decide in the ultimate. Farsighted citizens are contemplating a relatively active role for us in the period of postwar stabilization, since we are the creditor nation of this game. The tradition of poker will probably prevail, and we will have to stay in and play our chips lavishly to avoid the next morning remorse and bitterness on the part of those who up to now have been losers in international politics. Mind you, I am not advocating this policy, but I well remember the attitude of our debtors after the last game and likewise the attitude of our nationals, and, by the way, as physicians we should take an intelligent part in shaping a postwar policy for this nation. Enlightenment will beg elucidation. Educated men in each community must serve to expedite it.

Prepaid Medical Service

A huge and expensive structure will be an actuality for years to come in the attempt to stave off the inevitable shakedown in our internal economy. A staggering load of interest already faces us; the recipients of this interest will be vested interests and substantial people, since most of the securities purchased in patriotic zeal will have been sold shortly after the victory parade makes Broadway or Main Street a headache for street sweepers. The public's job will be to pay the freight in taxes. A veterans' program will entail commitments of colossal sums for years. Whatever of this program laps over into the general public's domain will likewise be expensive. All these lead up to a heavy tax burden on John Q. Public, and the plight of the common man may be a far cry from the halcyon twenties or early forties and be sharply reminiscent of the early thirties.

I am not a prophet of doom, but neither am I an incurable visionary living in pink clouds. I keep wondering what and how. I know that the common man and the middle class will have much less money uncommitted to bare necessities and taxation. A plan for meeting catastrophic illness will be a boon to all peoples under the economically substantial level. That it will be elaborated is a verity. Medicine must embrace the theory and establish a pattern. The insurance principle will be the modus operandi.

I believe that indemnity on a cash basis makes for greater economy in the overall expense of illness without penalty to the conscientious practitioner adopting such practice.

Institutional Care

The next subject I believe worthy of consideration by this body is the matter of medical disciplines in institutional care as they apply to our state and county asylums, training schools, and corrective institutions. You are all aware of the internecine quarrel in the Board of Public Welfare growing out of difference in emphasis by members of that board and the executive director in carrying out their assignment. The press has entered the fray and so has your Society, but we only within our jurisdiction in public health and only in that projection can we continue our efforts toward solution of a vexing problem. I have previously appointed a committee to investigate the possibilities for guidance in the solution and in setting up acceptable standards of procedure.

Certain it is that radical departures from present practice will be forthcoming as a result of our studies. The question before this body is to what extent shall we participate and how shall we deport ourselves in bringing pressure to bear for fulfillment of our objectives.

It is my opinion that we, who assume custodianship for public health in its medical aspects and recognize no other agency capable of rationalizing in this domain, must take the lead first in assaying the problem and then, through the agency of our Committee on Public Policy and the pressure each physician can bring to bear through county and state legislative contacts, push through for adequate financial implementation and properly trained personnel to attain the desideratum.

The Committee on Mental Hygiene and Institutional Care has, in the August issue of *The Journal*, given a comprehensive survey of the problem of county institutions and outlined a well rounded program for their betterment. I hope Dr. Hughes or Dr. Christofferson will amplify their conclusions before this body. I direct their report to your attention for leisurely study and definitive action. I am intrigued by the great opportunity for positive action by this Society and the possibility of great social gain to our state by allied action of the Board of Public Welfare, the press, and the public to achieve a level of care for those unfortunately temporarily or permanently removed from society and confined to one of our institutions. A progressive and enlightened state cannot subjugate human values to profit and loss accounting or animal hus-

bandry or the whims and fancies of a "gauleiter" who might assume prerogatives not intended by statute.

Nursing Education

The matter of nursing education itself is a very vexing one. Our committee has tried very diligently to effect some change in the program, modifying the demand to a scale that would make for greater efficiency in the hospital itself, giving hospitals greater service for the training that they give these girls and also scaling down some of the requirements that are now being introduced into the curriculum.

Dr. Munn and his committee have done a grand piece of work, but to date have had relatively little success because of the influence of national nursing associations which do not take very kindly to physicians' meddling in their teaching and training activities.

Industrial Health

It is essential that we carry on this program for some years to come. Much good has accrued from our activities in the last year. I think we have effected a liaison with the manufacturers that will be of great value to us in medicine. They have entered into more deliberations and have manifested some interest in our espousement of their problems.

I believe we should have a committee on farm health and accident prevention. I believe this committee should set up a program through our Council on Scientific Work, which should be carried to the rural areas of the state of Wisconsin. I am certain that if the proper time of year is chosen—the time when farmers are not too busy with other activities—they will welcome an opportunity to see and hear some of the things that could be gotten together to protect their health and to warn them against faulty practices which lead to accidents on the farm.

Nutrition

Another allied subject strikes me as being extremely important at this time, and that is the matter of nutrition. To the best of my knowledge, the only work in this field that has been done has not come through medical sources. It has been a program carried on by large industries.

I would like to see a committee appointed, headed by Dr. Sevringhaus, if he will accept such an appointment, which will engage very actively over a long term in teaching sound nutritional information. I am sure a program could be worked out, and I am sure it would have public acceptance. I am more than certain it would do great good in the State of Wisconsin.

Tropical Medicine

I also feel that we should set up some program that would keep our members abreast of the developments in tropical diseases. As you know, practically every form of tropical disease is appearing in our soldiers and sailors in the many lands in which they are fighting, and, unless we are familiar with the varying manifestations of these diseases and the possibility of new vectors being developed in our local communities when they return, we may have a serious problem on our hands.

I have wandered all over the lot in trying to convey to you some of the things that occurred to me during the summer while thinking about this Annual Meeting. The field of medical economics is very broad. There are numerous approaches to it. Some approaches one fears to enter.

In no way do I wish to convey the thought that this body and our Council and our officers in general have not given every consideration it is possible to give in the light of what is known, but we must remember that from year to year facts and fancies accumulate very rapidly, and we should be kept current and should be true statesmen of medicine and should make some attempt to make something out of the practice of medicine which will lead to the objective of all parties concerned.

At the conclusion of Dr. Kurten's report, the meeting recessed at 7:15 p. m. for supper and reconvened at 8:20 p. m.

Report of the Treasurer

The Speaker called for the report of the treasurer, Dr. Ira R. Sisk, Madison, which, in the absence of the treasurer, was read by Secretary Crownhart.

In the inability of the Treasurer to be present this evening, I have been instructed to substitute for him and to present to the House the status of the Society during and at the close of 1942:

Income from normal "expendable sources"—the dues received from members—totals $59,702.12, $1,100 of which was received on account of former years. In addition to this income, there was a total of $1,183.12 received as interest on investments. Not included in this total were the sums received in connection with the Annual Meeting or postgraduate centers, which were treated as revolving funds under the Society's accounting procedures.

Normal budget expenditures may be summarized as follows:

1. Constitutional Officers and Committees	$11,244.01
2. Staff Salaries exclusive of Secretary	12,346.64
3. Administrative expense	8,330.49
4. Special Services to Membership	10,788.59
5. Public Health Special Services	3,076.24
6. Allocated appropriations carried over	7,652.45
Total	$53,438.42

In the report of the Auditing Committee to the Council given this morning, it was pointed out that the reserve of the Society at the close of 1942 totalled $42,642.16 augmented by a further allotment of $4,000 in the early part of 1943. Bonds held by the Society are as follows:

Description	Interest Rate	Maturity Date	Face Value	Market or Quoted Value
Pacific Telephone and Telegraph Company	3¼%	12–1–66	$2,000	$2,175.00
Milwaukee Gas Light Company	4½%	3–1–67	3,000	3,157.50
Dayton Power and Light Company	3 %	1–1–70	3,000	3,153.75
Wisconsin Power and Light Company	3¼%	8–1–71	3,000	3,157.50
United States Treasury	3¼%	4–15–46/44	2,000	2,062.00
United States Treasury	2½%	9–15–72/67	3,000	3,005.40
Pennsylvania Power and Light Company	3½%	8–1–69	2,000	2,127.50
Southern California Edison Company, Ltd.	3 %	9–1–65	2,000	2,055.00
Wisconsin Gas and Electric Company	3½%	4–1–66	1,000	1,085.00
United States Savings Defense, Series G	2½%	6–1–54	6,000	6,000.00
United States Savings Defense, Series G	2½%	6–1–53	2,000	1,956.00
United States War Savings, Series G	2½%	9–1–54	3,000	3,000.00
Total Face Value			$32,000	
Total Securities Owned				$32,934.65

In conclusion, Mr. Speaker, I should like to refer the attention of the House to the report of the Auditing Committee, presented to the Council this morning, which "commends the treasurer for the careful attention he has given the Society's investments and commends the officers of the Society for the manner in which the accounting procedures are followed and the safeguards that have been devised to assure all reasonable protection to the Society disbursements. It reports a completely satisfactory financial review for the year 1942."

There followed a supplementary report by the secretary, showing a total membership of 2,607, as compared with 2,610 a year ago.

Dr. C. A. Dawson, River Falls, was called upon as chairman of the Committee on Public Policy and thanked the membership for its cooperation during the last year.

Dr. Erwin Schmidt, Madison, chairman of the Council on Scientific Work, discussed the efforts of the Council during the last year and commended to the House "the recommendation of the Council for that amendment to the By-laws which would provide discretion being given to the Council on Scientific Work as to the length of time afforded to our out-of-state guest speakers on our annual meeting program. The present By-laws provide that no one shall be permitted to present a manuscript of more than twenty minutes in length."

Dr. Schmidt presented the following resolution: "The Council on Scientific Work recognizes and commends the outstanding work of Mr. George B. Larson, assistant secretary of the State Medical Society of Wisconsin, and the aid he has been to the Council in preparing the scientific program and the scientific exhibits."

Procurement and Assignment Service

Dr. R. E. Fitzgerald, Milwaukee, state consultant for the Procurement and Assignment Service, was called upon by the Speaker for a report of the activities of this organization. Dr. Fitzgerald's report follows.

Mr. Speaker, Delegates and Visitors: A year ago we certified or marked available some 647 doctors in this state; 613 were commissioned in 1942, and in 1943 we marked available 438 men, and seventy were commissioned.

This means that we marked available 1,085 men in this state, and 683 men have been commissioned up to the first of September. With the number of doctors who have been commissioned within the last few days, I believe our number will run well over 700.

In the last war we had something like 756 doctors and an army of 3,776,000. We now have an army of 8,000,000 and about 2,000,000 in the Navy. According to press releases, we expect that the Navy will increase that number 554,000, which will give them something like 2,500,000 in the Navy. This will mean an increase of about 3,000 more doctors for the Navy itself.

We have reached our 50 per cent objective for this year. We have no quota. We did have one in the beginning, but that quota was done away with about the middle of the year, and the Secretary of War tells us that he will take all men physically qualified, under the age of 45. That means for the rest of the year we will have to turn out about 5,000 doctors for the entire country.

Within the last few days we have been notified that the state chairmen will have to certify a certain number of doctors for the Coast Guard. Our objective, as you will realize, is a heavy one. The mortality rate and replacement rate will run about 12 per cent for the entire country. That means the number of men killed in action, or the deaths caused due to disease, and so on, and the replacement of men who have been relieved and sent back to civilian life.

As I see it, for the rest of the year we are going to have quite a problem to complete our objective.

As you know, we are busy on sixty-five fronts, and we have had to give medical care and treatment in those particular areas. As time goes on and we get closer to the bottom of the barrel, the question arises, "How many doctors can we spare in this state?"

As you realize, at the beginning of this war we had 82,000 men within draft age who would be subject to the draft if necessary. Out of that 82,000 we have 48,000 men now in service. I have always said that before this war is over we will have about 60,000 in service. That is my own private estimate of the number of doctors who will see service.

During the last year we have had several changes. As you recall, the first of the year the Adjutant General took over procurement of doctors but left it in the hands of Procurement Service physicians to decide who was to be marked available. A little later they decided that the individual procurement office could get in touch with each doctor and talk to him about his duty.

Just exactly who or what type of individual will be reexamined, and what his disqualifications are,

will be decided by the Secretary of War. They say that all doctors with minor defects will be reexamined. Up to date we have had physicians who have had diabetes, double hernia, and so on, asked to be sent back for reexamination. So I don't know where this is going to end or how far they are going to go in the reexamination of physicians.

I will say, however, that about 47 per cent of the doctors examined have been disqualified up to the present time. I believe this state can stand about another 100 doctors for the service.

We have marked throughout the state, I would say, close to 1,500 men who, in case of dire necessity, could be marked and made available. If we run 800 men, I think we will have reached the bottom of the barrel.

We no longer could give the proper medical care to the civilian population. Of course, you realize, as your President has said this evening, that our first objective is to win the war. How are we going to do that? We must have a great army, and in order to take care of that great army we will have to have a large number of doctors in service.

As far as the Procurement and Assignment Service in this state is concerned, we have interviewed about 150 doctors besides industrial men, hospital heads, et cetera. As you noticed in the last *Journal of the American Medical Association*, there is again another change that has taken place. The interns will no longer serve for twelve months; they will serve instead for nine months, and we will have three distinct divisions: intern, assistant resident and resident, and the longest period they can serve will be twenty-seven months.

It will be up to the individual hospital to see to it that it can get its own individual residents, assistant residents and interns. I believe if the hospital will pay a sufficient amount of money to the residents and the interns, they will have a better opportunity.

I grant you we are having quite a little competition from industry and other organizations who are paying fancy prices to 4-F men. I had a case just the other day. I had a man all set for the residency in one of the hospitals when he received a proposition from an industrial unit which about tripled what he would get in the hospital.

In conclusion, I want to thank the many different committees in the state who have been so helpful to us. It has been a terrific job for these men to go out and mark and examine the many doctors in the various communities, but they realize, as most of us do, and we feel as our Surgeon General does, that the more doctors we have in the front line trenches the fewer one-armed, one-legged and sightless men will come back to our communities.

Emergency Medical Service

The Chair next called upon Dr. J. S. Supernaw, Madison, state chief of Emergency Medical Service under Civilian Defense, who discussed the activities of this organization in Wisconsin up to the present time.

Dr. C. O. Vingom was called upon to present the report of the Committee on Coordination of Medical Services.

Delegates to the American Medical Association

At this point, the Speaker called for reports of the delegates to the American Medical Association, Dr. Joseph F. Smith, Wausau; Dr. S. E. Gavin, Fond du Lac; and Dr. James C. Sargent, Milwaukee, now in service with the U. S. Navy. Dr. Smith, Dr. Gavin and Dr. A. E. Rector, Appleton, alternate for Dr. Sargent, reported on the 1943 annual session in Chicago.

Committee on Nominations

The next order of business, as announced by the Speaker, was the selection of a Committee on Nominations, and a recess was taken to permit caucus by the delegates of the various councilor districts.

After recess, results of the selections for the nominating committee were announced as follows: First district, F. G. Bachhuber; Second, W. C. Stewart; Third, C. O. Vingom; Fourth, George Parke; Fifth, E. C. Cary; Sixth, Guy W. Carlson; Seventh, W. M. Trowbridge; Eighth, A. A. Cantwell; Ninth, J. K. Trumbo; Tenth, L. O. Simenstad; Eleventh, R. O. Grigsby; Twelfth, L. W. Hipke; Thirteenth, W. S. Bump. Upon motion by Dr. H. H. Christofferson, Colby, seconded by Dr. J. F. Smith, Wausau, the above personnel of the Committee on Nominations was approved by the House, and the Secretary announced provision for the meeting of the Committee on Nominations for the following morning.

Red Cross Volunteer Nurse Aides and Gray Ladies

President Kurten presented the following resolution:

"WHEREAS, The record of the Red Cross Volunteer Nurse Aides in the State of Wisconsin from July 1, 1941, to June 30, 1943, reveals that 2,750 were enrolled, including 700 now in training, that 2,073 certificates were issued, and that 195,567 hours were served, the overwhelming majority of which were spent in hospital service, and

"WHEREAS, This record bears witness to the efforts of these Wisconsin women to do what they can to help win the war and through a willing sacrifice of time and strength in the face of present needs and in preparation for a possibly even more acute dearth of home-front physicians and trained nurses, and

"WHEREAS, The status of public health in the State of Wisconsin for the duration will be protected in large measure through such unselfish assistance as is given by the nurse aides,

"*Now therefore be it resolved*, That we as members of the House of Delegates of the State Medical Society of Wisconsin, in a spirit of admiration and gratefulness, do extend to the Red Cross Volunteer Nurse Aides in the State of Wisconsin our sincere appreciation for their patriotic execution of an essential job well performed."

Dr. C. M. Echols, Milwaukee, amended the resolution to include the Gray Ladies.

After announcement by the Secretary as to time and place of meetings of the various reference committees of the House, functions in connection with the Annual Meeting, and similar matters, the House adjourned until 7:00 p. m., Monday evening, September 13.

MONDAY SESSION

The House of Delegates was called to order by the Speaker at 7:10 p. m., Monday evening, September 13, in the Crystal Ballroom of the Hotel Schroeder, this constituting the second session of the House. The report of the Committee on Credentials was read, and a quorum was declared present. Upon motion by Dr. W. M. Trowbridge, Viroqua, seconded by Dr. H. J. Gramling, Milwaukee, the report was adopted.

At this time Secretary Crownhart read the following telegram: "I wish we were together on this special occasion. All my best wishes for a speedy reunion. Good luck. Keep it up. Signed, Roman Galasinski." Dr. Galasinski is at the present time serving with the United States Navy.

Report of Committee on Reports of Officers and Standing Committees

Dr. A. M. Christofferson, Waupaca, chairman of the Committee on Reports of Officers and Standing Committees, presented the recommendation of the Committee that the report of the President be accepted. Upon motion of Dr. Christofferson, seconded by Dr. E. C. Cary, Reedsville, the report of President Kurten was adopted in its entirety.

Upon motion of Dr. Christofferson, for the Committee, seconded by Dr. O. H. Eppley, New Richmond, the report of the Treasurer was adopted.

Upon motion of Dr. Christofferson, for the Committee, seconded by Dr. C. R. Marquardt, Milwaukee, the report of the Secretary was adopted.

Dr. Christofferson presented the recommendation of the Committee that the following reports be accepted: The Council on Scientific Work, the Committee on Cancer, the Advisory Committee on the Care of Crippled Children, the Committee on Health and Public Instruction, the Committee on Industrial Health, the Committee on Tuberculosis and Chest Diseases, the Committee on Public Policy, the Committee on Coordination of Medical Services, the delegates to the American Medical Association, and the Committee on Grievances. Upon motion of Dr. Christofferson, seconded by Dr. R. L. MacCornack, Whitehall, these reports were accepted.

Upon motion of Dr. Christofferson, for the Committee, seconded by Dr. G. W. Carlson, Appleton, the report of the Committee on Hospital Relations was adopted.

Upon motion of Dr. Christofferson, for the Committee, seconded by Dr. E. H. Spiegelberg, Boscobel, the report of the Committee on Mental Hygiene and Institutional Care was adopted.

Upon motion of Dr. Christofferson, for the Committee, seconded by Dr. C. M. Echols, Milwaukee, the report of the Committee on Reports of Officers and Standing Committees was adopted in its entirety.

Report of Committee on Resolutions and Amendments to Constitution and By-Laws

Dr. K. H. Doege, Marshfield, chairman of the Committee on Resolutions and Amendments to Constitution and By-laws, offered the report of that reference committee as follows:

The report of the Council was referred to your committee in view of the fact that it contains reference to Council action taken in January, 1943, creating Section XI, Chapter 10, of the By-laws to provide in effect that the State Medical Society will recognize the action of any county medical society in creating a special service classification for those with the armed forces who are licensed to practice in Wisconsin, but not previously affiliated with any county medical society.

This amendment was voted by the Council, acting under unusual powers, in order to preserve the integrity of the medical societies and to provide newly licensed physicians with opportunity for affiliation with county societies for the duration, thereafter submitting to reelection if they desire to continue that affiliation in private practice.

Upon motion by Dr. Doege, for the Committee, seconded by Dr. R. O. Grigsby, Ashland, the proposed amendment was put to a vote and declared adopted.

Special Committee of the President, Advisory to the State Department of Public Welfare

This committee was created with the approval of the Executive Committee of the Council and has the responsibility of consulting with the State Department of Public Welfare in those several matters in which the advice and assistance of the medical profession is essential to an adequate discharge of the responsibilities of the state in the administration of the institutions under the direction of that department.

The committee has just begun to function, and in the light of this and the responsibilities of the committee, your reference committee believes that in its judgment this committee has undertaken a most important function and that it will demonstrate to the profession, as well as to the public, the need for continued medical supervision in these fields. It commends the President and the Executive Committee of the Council for their action in this respect.

Upon motion of Dr. Doege, for the Committee, seconded by Dr. C. J. Weber, Sheboygan, the report was voted upon and declared adopted.

Committee on Nursing Problems

Your reference committee commends the activities of the Committee on Nursing Problems and feels

that it has accomplished great good in this field. The committee suggests that the House of Delegates authorize its continuance as a special committee empowered to act through the Council and the Committee on Public Policy as a liaison agency between the medical profession and the nursing interests of Wisconsin.

Upon motion of Dr. Doege, for the Committee, seconded by Dr. F. A. Douglas, La Crosse, the recommendation of the Committee was voted upon and adopted.

Conference Committee on Open Panels

The report of this committee relates to the distribution of over 50,000 panels to Wisconsin employers during 1943. It emphasizes that these panels had been prepared in such a manner as to identify those physicians who have entered service and suggests activities in the field of simplification of report forms.

In addition to these matters, the committee reports with reference to the complaints made as to the compliance with the Open Panel Agreement on the part of both the physicians and the insurance carriers and its recommendations to the Committee on Industrial Health and the Council on Scientific Work relating to industrial health programs for physicians.

Upon motion of Dr. Doege, for the Committee, seconded by Dr. R. G. Baker, Tomahawk, the report of the Committee was voted upon and accepted.

Annual Registration Act

The report of the Committee to Study the Medical Practice Act summarizes the developments during the last year concerning the Annual Registration Act and recommends that this committee should be continued from year to year to serve in administrative matters concerning the annual registration law as well as in topics which are presented from time to time relating to the Medical Practice Act.

Upon motion of Dr. Doege, for the Committee, seconded by Dr. L. J. Van Hecke, Milwaukee, the motion was voted upon and carried unanimously.

Resolution Relating to Hygeia

This resolution follows, in the main, a similar resolution accepted in Michigan. It commends the contribution made by *Hygeia*, the health magazine, and offers support to the Woman's Auxiliary in its efforts to secure wider distribution and recognition of that publication. Your reference committee recommends its adoption.

Upon motion of Dr. Doege, for the Committee, seconded by Dr. H. H. Christofferson, Colby, the proposed amendment was put to a vote and declared adopted.

Committee on War Participation

The reports of the Committee on War Participation, and of Dr. J. S. Supernaw and Dr. R. E. Fitzgerald in the fields of civilian defense and the Procurement and Assignment Service for Physicians, respectively, reveal the activities of the medical profession in the discharge of its responsibilities to the people in time of war.

The Committee on War Participation was created as a result of Council action following the annual meeting of the American Medical Association in 1942, and its organization follows the procedures recommended by a similar committee on a national level. Through its Subcommittees on Procurement and Assignment Service, Replacements, and Civilian Defense, the activities of the Society are guided in consistent channels of cooperation.

Upon motion of Dr. Doege, for the Committee, seconded by Dr. W. M. Trowbridge, Viroqua, the motion was voted upon and carried unanimously.

Nurse Aides and Gray Ladies

In supplementing the resolution offered by Dr. Kurten commending the activities of the Red Cross Nurse Aides, your committee recommends to the House the adoption of the following resolution:

"WHEREAS, Many generous and public spirited women are willingly participating in the efforts of the Gray Ladies of The Red Cross to advance the comfort of patients and hospitalized veterans in many of the hospitals of Wisconsin, and

"WHEREAS, This work requires unbounded energy and careful preparation and is a distinct contribution to the efforts of the nation during this wartime period; now, therefore, be it

"*Resolved*, By the State Medical Society of Wisconsin, represented in the House of Delegates, that it voice for the medical profession of the state as well as for an appreciative citizenry the appreciation and gratitude that is due the Gray Ladies of The Red Cross."

Upon motion of Dr. Doege, for the Committee, seconded by Dr. C. M. Echols, Milwaukee, the resolution was voted upon and carried unanimously.

The resolution commending the record of Red Cross Volunteer Nurse Aides in the State of Wisconsin over the last two years notes, particularly, the number of women participating and the extent to which they have contributed to the war effort in relieving local situations that are becoming increasingly widespread as more physicians and nurses enter the services of this country.

Upon motion of Dr. Doege, for the Committee, seconded by Dr. R. L. MacCornack, Whitehall, the resolution was voted upon and carried unanimously.

Dr. Doege, for the Committee, moved the adoption of the report of the Reference Committee in its entirety. Seconded by Dr. J. M. Fons, Milwaukee, the motion was voted upon and carried unanimously.

Executive Sessions

Dr. C. M. Echols, Milwaukee, chairman of the Committee on Executive Sessions, stated that the committee had examined the agenda for the remainder of the meeting Monday evening and Tuesday morning, and the committee was of the opinion that

all of the deliberations on the subjects for the rest of the evening and the following morning should be in executive sessions.

Dr. Echols so moved, and, seconded by Dr. J. K. Trumbo, Wausau, the motion was voted upon and carried unanimously.

Dr. Doege, continuing his report as chairman of the Committee on Constitution and By-laws, read the report of the Special Report of the Reference Committee on Resolutions and Amendments to Constitution and By-laws, as follows:

The Committee on Maternal and Child Welfare recommends that:

1. The Council of the State Medical Society of Wisconsin, the Committee on Public Policy, and the State Board of Health be urged by this House of Delegates to continue to seek the establishment of the Emergency Maternal and Infant Care Program as urged in its report.

2. The Council of the Society, the State Board of Health, and the Committee on Public Policy be urged to make every effort to secure administration of the program to provide obstetric and pediatric care for the wives of men in service so as to avoid the arbitrary regulations now in effect which strip from the State Board of Health any vestige of local discretion.

3. The medical corps of the several branches of the armed forces have established high standards of qualifications of those who are to serve as medical officers, and your committee recommends that in the extension of care to the wives and children of men in the armed services, the same high qualifications should be maintained.

Your committee moves adoption of the report of the standing committee and its recommendation, with the further recommendation that any such plan for the emergency maternal and infant care of wives and children of men in service be developed for the duration of the war only.

Dr. Doege, for the Committee, moved acceptance of this report. After considerable discussion by Dr. W. C. Stewart, Kenosha, Dr. P. R. Minahan, Green Bay, Dr. A. E. Rector, Appleton and Dr. Carl Neupert, Madison, the motion, variously seconded, was unanimously carried.

Dr. Doege read that part of the Special Report dealing with dues, as follows:

Your reference committee has reviewed the financial affairs of the Society in detail. It has considered the particular problems with which the medical profession is confronted with reference to the pending proposals for the change of the economic system under which the individual physician would be able to engage in practice, and particularly the need for the further and wider dissemination on the state level of information to the public concerning these vital projects.

Your committee has considered the membership roll and the probability that confronts the organized medical profession as the war effort demands the enrolment of a greater number of physicians than are represented in the armed services at the present time.

In view of this study, it is the committee's recommendation that the Society avail itself of a fund of at least $2,000 with which to foster the basic principles of the proposal outlined in this report to protect the integrity of the medical profession for the men in service as well as those who remain on the home front.

In consideration of these circumstances, your reference committee recommends that the dues for the ensuing year of 1944 be established in the sum of $33.

Dr. Doege, for the Committee, moved acceptance of the report. Dr. J. K. Trumbo, Wausau, seconded the motion. After discussion by Dr. F. A. Douglas, La Crosse, Dr. W. C. Stewart, Kenosha, Dr. C. M. Echols, Milwaukee, and Dr. K. H. Doege, Marshfield, the motion was voted upon and carried.

At this point in the proceedings, Dr. Gavin, chairman of the Council, presented the following supplementary report of the Council:

The Council on Scientific Work recommended to the Council that consideration be given to a revision in the By-laws of the Society to provide more elasticity in the preparation of the scientific programs. The By-laws now provide that no paper presented at the annual sessions shall exceed twenty minutes in length, except those of the president, the president-elect and the annual orations. To make it possible to extend the length of this time in the case of certain out-of-state guest speakers the Council on Scientific Work has asked for this revision.

In accordance with this wish the Council submits the following amendment to the By-laws and recommends its adoption:

"Section 2. No address or paper, except those of the president, the president-elect, and the annual orations shall occupy more than twenty minutes in its delivery. Out-of-state guest speakers may be allotted thirty minutes for the delivery of scientific papers. No member, except by unanimous consent, shall speak more than once in the discussion of any paper nor longer than five minutes at any one time."

Mr. Speaker, I offer this By-law to the House and ask that it be referred to the proper reference committee.

The House recessed at 8:40 p. m. until Tuesday morning to permit members and guests to attend the Annual Smoker.

TUESDAY SESSION

The House reconvened at 8:20 a. m., Tuesday morning, September 14, in the Banquet Room of the Hotel Schroeder, this being a continuation of the second session.

Speaker Fidler read the following telegram from Commander J. C. Sargent:

"Greetings to you, Mr. Speaker, and to the officers and delegates assembled. While other duties prevent my attendance at this session of our House of Delegates, I shall follow carefully and with great interest your deliberations and the business you conduct

on behalf of Wisconsin doctors. These are disquieting times, and great responsibility rests with each of you. A large group of us temporarily detached and inarticulate rely upon you to maintain the unity and the high principles of our profession. Best wishes for a most successful meeting.

J. C. SARGENT, *Commander, USNR.*"

Dr. A. M. Christofferson, chairman of the Committee on Standing Committees, read the report of the Committee as follows: "Your reference committee is fully cognizant of the position which has been taken by this House of Delegates on previous occasions that Radiology, Pathology, and Anesthesiology are medical services and should not be included in any hospital service plan as a service benefit.

It is the considered opinion and judgment of your reference committee that strict adherence to this policy be maintained and that the House of Delegates instruct the Committee on Medical Economics and Voluntary Sickness Insurance to continue to adhere to this policy and that the special services of Radiology, Pathology, and Anesthesiology be included in any prepaid medical service plan as sponsored by the Society.

Dr. Christofferson, for the Committee, moved adoption of the report.

After considerable discussion, lead by Dr. Dexter Witte, Milwaukee, and President Kurten, the House voted to table the resolution.

THIRD SESSION

There being no further business before the House, upon motion of Dr. H. J. Gramling of Milwaukee, variously seconded, the House adjourned and immediately entered into its third session. The report of the Credentials Committee was accepted as constituting the roll of the House upon motion of Dr. W. M. Trowbridge, Viroqua, seconded by Dr. E. C. Cary, Reedsville.

The Speaker announced the first order of business required under the By-laws as being the report of the Committee on Nominations and reminded members of the House that nominations by that Committee do not necessarily preclude other nominations from the floor.

Election of Officers

Dr. F. G. Bachhuber, Mayville, presented the report of the Committee on Nominations in the form of a ticket, as required in the By-laws, containing the name of a nominee for each office as follows:

For president-elect—Dr. Charles Fidler, Milwaukee;

For speaker of the House of Delegates—Dr. P. R. Minahan, Green Bay;

For vice-speaker—Dr. C. A. Dawson, River Falls;

For delegate to the American Medical Association—Dr. W. D. Stovall, Madison; to succeed Dr. J. F. Smith, Wausau, whose term expires;

For alternate delegate to the American Medical Association—Dr. H. A. Sincock, Superior, to succeed Dr. C. W. Geisen, whose term expires.

Place of the 1944 annual meeting—Milwaukee.

There being no further nominations, upon second by Dr. G. W. Carlson, Appleton, the Secretary was instructed to cast the unanimous ballot of the House for Dr. Charles Fidler, Milwaukee, as president-elect.

There being no further nominations, upon second by Dr. Carlson, Dr. P. R. Minahan was unanimously elected as speaker of the House of Delegates.

There being no further nominations, upon second by Dr. L. O. Simenstad, Osceola, Dr. C. A. Dawson was unanimously elected vice-speaker of the House of Delegates.

There being no further nominations, upon second by Dr. R. L. MacCornack, Whitehall, Dr. W. D. Stovall, Madison, was unanimously elected delegate to the American Medical Association.

There being no further nominations, upon second by Dr. L. O. Simenstad, Osceola, Dr. H. A. Sincock, Superior, was unanimously elected alternate delegate to the American Medical Association.

Upon second by Dr. C. O. Vingom, Madison, the place of meeting for the 1944 session was designated as Milwaukee.

Election of Councilors

Dr. Louis Fauerbach, Madison, placed in nomination the name of Dr. C. O. Vingom, Madison, as councilor for the third district. Upon second by Dr. R. G. Baker, Tomahawk, the Secretary was instructed to cast the ballot of the House for Dr. Vingom.

Dr. George Parke, Richland Center, placed in nomination the name of Dr. E. H. Spiegelberg, Boscobel, as councilor for the fourth district, announcing that the present councilor, Dr. B. I. Pippin, did not desire to be considered for reelection. There being no further nominations, upon second by Dr. L. O. Simenstad, Osceola, the Secretary was instructed to cast the ballot of the House for Dr. Spiegelberg.

Dr. E. C. Cary, Reedsville, placed in nomination the name of Dr. A. H. Heidner, West Bend, to succeed himself as councilor from the fifth district. There being no further nominations, upon second by Dr. C. J. Weber, Sheboygan, the Secretary was instructed to cast the ballot of the House for Dr. Heidner.

Dr. A. G. Taylor, Oshkosh, placed in nomination the name of Dr. S. E. Gavin, Fond du Lac, to succeed himself as councilor from the sixth district. There being no further nomination, upon second by Dr. J. S. Supernaw, Madison, the Secretary was instructed to cast the ballot of the House for Dr. Gavin.

Dr. L. W. Hipke, Milwaukee, placed in nomination the name of Dr. R. W. Blumenthal, Milwaukee, as councilor from the twelfth district to succeed himself. There being no further nominations, upon second by Dr. J. M. Fons, Milwaukee, the Secretary was instructed to cast the ballot of the House for Dr. Blumenthal.

Introduction of President-Elect Fidler

Dr. Charles Fidler, Milwaukee, was introduced as president-elect and addressed the House as follows:

I am sorry, in a way. I think I kind of like this job I have had here. I think that in another year I would have enjoyed it more. It is a lot of fun.

Dr. Sargent, the year after his presidency, sat in the audience with me and said, "There is nothing so dead as a past-president."

I wouldn't like to die. I have been very active in the work of organized medicine for a long, long, time, and I would like to continue to work in medicine. I don't want to die, and I don't want to feel that I am in the last spot just before jumping off. I do feel that being president of the State Society has some honor; I don't believe it is so vitally important to the running of the Society. I believe the Council does a very good job of that, but I want you to know that whatever duty comes my way, it will receive my most earnest attention.

Dr. Doege presented the report of the Council, made at the request of the Council on Scientific Work, for modification of the By-laws.

Upon motion by Dr. Doege for the Committee, seconded by Dr. R. L. MacCornack, Whitehall, the motion was voted upon and carried unanimously.

Resolution Commending Dr. J. F. Smith

Dr. F. G. Bachhuber, Mayville, introduced the following resolution:

WHEREAS, For many years Dr. Joseph F. Smith of Wausau has held close and dear to his heart the inseparable interests of the public and the profession, and

WHEREAS, The Council of the State Medical Society of Wisconsin, in recognition of his work, awarded him the highest honor within the Society's power to bestow, and

WHEREAS, For many years he has been a conscientious and capable representative of this Society to the House of Delegates of the American Medical Association,

Now, therefore, be it resolved, That this House of Delegates convey to Doctor Smith its heartfelt appreciation for the services he has rendered.

Upon second by Dr. R. O. Grigsby, Ashland, the motion was voted upon and carried unanimously.

Appointments to Standing Committees

Secretary Crownhart read the President's committee appointments which will appear in full in the January issue of *The Wisconsin Medical Journal.* Committee appointments announced were confirmed.

Dr. A. M. Christofferson, Waupaca, stressed the importance that a record of the veterans of this war be maintained by physicians, in accordance with a resolution passed by the state legislature at its last session. Dr. R. L. MacCornack, Whitehall, moved that the Secretary be instructed to issue those instructions in letter form to the various members of the Society. Upon second by Dr. A. G. Koehler, Oshkosh, the motion was voted upon and carried. Upon motion of Dr. W. M. Trowbridge, Viroqua, variously seconded, the House of Delegates to the One Hundred Second Annual Meeting adjourned sine die at 11:05 a. m.

Attendance at House of Delegates, Milwaukee, 1943

Society	*Delegate*	*Sessions* 1	2	3
Ashland–Bayfield–Iron	R. O. Grigsby, Ashland	x	x	x
	J. W. Prentice, Ashland*	x	x	x
Barron–Washburn–Sawyer–Burnett	D. L. Dawson, Rice Lake	a	a	a
	S. O. Lund, Cumberland*	x	x	x
Brown–Kewaunee–Door	P. R. Minahan, Green Bay	x	x	x
	E. S. McNevins, Green Bay*	a	x	x
	O. A. Stiennon, Green Bay	x	x	x
	W. E. Leaper, Green Bay*	a	a	a
Calumet	A. C. Engel, New Holstein	a	a	a
	P. J. Wollersheim, Forest Junction*	a	a	a
Chippewa	A. J. Somers, Chippewa Falls	a	a	a
	Frank Sazama, Chippewa Falls*	a	a	a
Clark	H. H. Christofferson, Colby	x	x	x
Columbia–Marquette–Adams	L. V. McNamara, Montello	x	a	a
	E F. Tierney, Portage*	a	a	x
Crawford	E. M. Dessloch, Prairie du Chien	x	x	x
	G. R. Hammes, Seneca*	a	a	a
Dane	C. O. Vingom, Madison	x	x	x
	J. E. Gonce, Jr., Madison*	a	a	a
	A. R. Tormey, Madison	x	a	a
	W. H. Marsden, Madison*	a	a	a
	J. S. Supernaw, Madison	x	x	x
	L. R. Cole, Madison*	x	x	x
	Louis Fauerbach, Madison	x	x	x
	N. A. Hill, Madison*	x	x	x
Dodge	W. E. Bargholtz, Reeseville	a	a	a
	F. G. Bachhuber, Mayville*	x	x	x
Douglas	J. W. McGill, Superior	x	x	x
	H. J. Orchard, Superior*	a	a	a
Eau Claire–Dunn–Pepin	W. R. Manz, Eau Claire	x	x	x
	B. F. Johnson, Mondovi*	a	a	a
Fond du Lac	D. J. Twohig, Sr., Fond du Lac	x	x	x
	D. N. Walters, Fond du Lac*	x	x	x

Society	Delegate	Sessions 1	2	3
Forest	G. E. Carroll, Laona	a	a	a
	H. C. Marsh, Crandon*	a	a	a
Grant	J. H. Fowler, Lancaster	a	a	a
	E. H. Spiegelberg, Boscobel*	x	x	x
Green	J. A. Schindler, Monroe	a	a	a
	L. E. Creasy, Monroe*	a	a	a
Green Lake–Waushara	J. A. Kelly, Green Lake	x	a	a
	H. C. Koch, Berlin*	a	a	a
Iowa	S. B. Marshall, Hollandale	x	x	a
	H. M. Walker, Dodgeville*	x	a	a
Jefferson	G. E. Eck, Lake Mills	x	x	x
	O. F. Dierker, Watertown*	x	a	a
Juneau	C. A. Vogel, Elroy	a	a	a
	A. R. Kaufman, Mauston*	a	a	a
Kenosha	W. C. Stewart, Kenosha	x	x	x
	L. T. Kent, Kenosha*	a	a	a
La Crosse	F. A. Douglas, La Crosse	x	x	x
	Jens Rosholt, La Crosse*	a	a	a
Lafayette	S. A. Ennis, Shullsburg	a	a	a
Langlade	C. E. Zellmer, Antigo	x	x	x
	W. P. Curran, Antigo*	a	a	a
Lincoln	R. G. Baker, Tomahawk	x	x	x
	K. A. Morris, Merrill*	a	a	a
Manitowoc	E. C. Cary, Reedsville	x	x	x
	T. H. Rees, Manitowoc*	a	a	a
Marathon	J. F. Smith, Wausau	x	x	x
	E. E. Flemming, Wausau*	a	a	a
Marinette–Florence	H. L. Jorgenson, Marinette	a	a	a
	R. W. Shaw, Marinette*	a	x	x
Milwaukee	C. R. Marquardt, Milwaukee	x	x	x
	M. C. Borman, Milwaukee*	a	a	a
	Charles Fidler, Milwaukee	x	x	x
	B. P. Churchill, Milwaukee*	a	a	a
	Irwin Schulz, Milwaukee	x	x	a
	M. W. Sherwood, Milwaukee*	x	a	a
	W. M. Kearns, Milwaukee	a	x	x
	J. E. Mulsow, Milwaukee*	a	a	a
	C. M. Echols, Milwaukee	x	x	x
	C. F. Conroy, Milwaukee*	x	a	a
	W. A. Ryan, Milwaukee	a	a	a
	T. F. McCormick, Milwaukee*	a	a	a
	Norbert Enzer, Milwaukee	a	a	a
	C. C. Schneider, Milwaukee*	a	a	a
	R. F. Purtell, Milwaukee	x	x	x
	Benjamin Lieberman, Milwaukee*	a	a	a
	R. E. Galasinski, Milwaukee	a	a	a
	W. L. MacKedon, Milwaukee*	x	x	a
	L. J. Van Hecke, Milwaukee	x	x	x
	S. M. Morton, Milwaukee*	x	x	x
	E. J. Carey, Milwaukee	x	a	a
	M. J. Fox, Milwaukee*	a	a	a
	S. M. Markson, Milwaukee	a	x	x
	Edgar Habeck, Milwaukee*	a	a	a
	J. C. Griffith, Milwaukee	x	x	a
	Mark Bach, Milwaukee*	a	a	a
	J. J. Pink, Milwaukee	x	x	a
	J. M. Fons, Milwaukee*	x	x	x
	L. W. Hipke, Milwaukee	x	x	x
	T. J. Aylward, Milwaukee*	x	x	a
	H. J. Gramling, Milwaukee	x	x	x
	Aaron Yaffee, Milwaukee*	x	x	x
	G. S. Flaherty, Milwaukee	a	x	a
	O. S. Sander, Milwaukee*	a	a	a
Monroe	C. S. Phalen, Sparta	a	a	a
	L. G. Scheurich, Tomah*	a	a	a
Oconto	A. F. Slaney, Oconto	x	a	a
	C. R. Kwapy, Oconto*	x	x	x
Oneida–Vilas	W. S. Bump, Rhinelander	x	x	x
	I. E. Schiek, Rhinelander*	a	a	a
Outagamie	G. W. Carlson, Appleton	x	x	x
	D. W. Curtin, Little Chute*	a	a	a
Pierce–St. Croix	C. E. McJilton, River Falls	a	a	a
	O. H. Epley, New Richmond*	x	x	a
Polk	L. O. Simenstad, Osceola	x	x	x
	K. F. Johnson, Frederic*	a	a	a
Portage	A. G. Dunn, Stevens Point	a	a	a
	E. Wisiol, Stevens Point*	a	a	a
Price–Taylor	J. D. Leahy, Park Falls	x	x	x
	L. E. Nystrum, Medford*	a	a	a
Racine	T. C. Hemmingsen, Racine	x	x	x
	E. J. Schneller, Racine*	x	a	x
Richland	George Parke, Sr., Viola	x	x	x
	G. H. Benson, Richland Center*	a	a	a
Rock	H. E. Kasten, Beloit	x	x	x
	W. A. Munn, Janesville*	x	x	x
Rusk	L. M. Lundmark, Ladysmith	a	a	a
	Woodruff Smith, Ladysmith*	x	a	a
Sauk	Roger Cahoon, Baraboo	x	x	x
	J. F. Moon, Baraboo	x	x	x
Shawano	A. A. Cantwell, Shawano	x	x	x
	O. F. Partridge, Mattoon*	a	a	a
Sheboygan	C. J. Weber, Sheboygan	x	x	x
	A. C. Radloff, Plymouth*	x	a	a
Trempealeau–Jackson–Buffalo	R. L. MacCornack, Whitehall	x	a	x
	Robert Krohn, Black River Falls*	x	x	x
Vernon	W. M. Trowbridge, Viroqua	x	x	x
	J. J. Rouse, Hillsboro*	a	a	a
Walworth	E. D. Sorenson, Elkhorn	a	x	a
	D. H. Jeffers, Lake Geneva*	a	a	a

Society	Delegate	Sessions 1	2	3
Washington–Ozaukee	Arnold Barr, Port Washington	x	a	x
	J. G. Hoffmann, Hartford*	a	x	a
Waukesha	R. E. Davies, Waukesha	x	x	x
	H. T. Barnes, Delafield*	x	x	a
Waupaca	A. M. Christofferson, Waupaca	x	x	x
	J. H. Murphy, Clintonville*	a	a	a
Winnebago	A. G. Koehler, Oshkosh	x	x	x
	J. P. Canavan, Neenah*	a	a	a
Wood	K. H. Doege, Marshfield	x	x	x
	F. X. Pomainville, Wisconsin Rapids*	a	a	a
Section on Cardiology	Albert Bryan, Madison	x	x	a
	Francis Murphy, Milwaukee*	a	a	a
Section on Ophthalmology and Otolaryngology	J. K. Trumbo, Wausau	x	x	x
	A. H. Pember, Janesville*	x	x	x
Section on Orthopedics	R. P. Montgomery, Milwaukee	a	a	a
	L. D. Smith, Milwaukee*	a	a	a
Section on Radiology	J. E. Habbe, Milwaukee	x	a	x
	L. V. Littig, Madison*	a	a	a

*—Alternate delegate. x—Present. a—Absent.

Minutes of the Council, Milwaukee, September 12, 1943

1. Call to Order

The Council was called to order by Chairman Gavin at 9:45 a. m.

2. Roll Call

The following members of the Council were present, constituting a quorum: Councilors Gavin, Hough, Pechous, Clark, Pippin, Christofferson, Arveson, Ekblad, Eberbach, Fitzgerald, Blumenthal and Leahy; Past-President Gundersen.

Ex officio members of the Council present were President Kurten, President-Elect Fidler, Treasurer Sisk, Speaker of the House of Delegates Minahan; also Secretary Crownhart and Assistant Secretary Larson.

Invited guests included Dr. J. F. Smith, Wausau, delegate to the American Medical Association, and Dr. A. E. Rector, Appleton, alternate delegate; Dr. C. A. Dawson, River Falls, chairman of the Committee on Public Policy; Dr. C. N. Neupert, Madison, State Health Officer; Dr. D. H. Witte, Milwaukee, chairman of the Committee on Medical Economics and Voluntary Sickness Insurance; Dr. Eben J. Carey, Milwaukee, and Dr. John McCabe, Milwaukee, president and president-elect, respectively, of The Medical Society of Milwaukee County; Mr. James O. Kelley and Mr. Ralph F. Weber, executive secretary and assistant executive secretary, respectively, of that society; Dr. F. T. Romberger, chairman of the Council, and Mr. T. A. Hendricks, executive secretary, of the Indiana State Medical Association; Doctors S. H. Baxter, president, E. M. Jones, president-elect, and W. L. Burnap, chairman of the Council, the Minnesota State Medical Association; Dr. George W. Post, president, Illinois State Medical Society; Dr. Olin West, secretary of the American Medical Association, Chicago; Dr. J. W. Truitt, chairman, Medical Extension Committee, The Medical Society of Milwaukee County; Dr. A. W. Adson, Rochester, Minnesota; and Dr. M. G. Cavanaugh, president, Wisconsin State Dental Society.

3. Approval of Minutes of July Meeting

On motion of Councilors Blumenthal–Fitzgerald, the minutes of the July meeting of the Council, as published in the September issue of *The Wisconsin Medical Journal*, were unanimously approved.

4. Dues Policy

Secretary Crownhart informed the Council of the action of the State Medical Society of Florida in requiring a Wisconsin physician to pay a full year's dues upon this physician's removing to Florida in the middle of the year. Our Society was requested by this physician to prorate his dues. There was discussion by Councilors Blumenthal, Gavin, Christofferson, Fitzgerald, Leahy, Clark, Dr. Olin West, and Secretary Crownhart. Upon motion of Councilors Christofferson–Clark, it was voted to refund the dues in this individual instance from the time this member joined the Florida society until the end of the year on a pro rata basis.

Upon motion of Councilors Christofferson–Blumenthal, it was voted that the secretary be instructed to transmit a message of appreciation to Major H. J. Lee, Winter General Hospital, Topeka, Kansas, formerly of Oshkosh, and to Lieut. N. C. Erdmann, Barnes General Hospital, Vancouver, Washington, formerly of Manitowoc, for their refusal to accept a pro rata rebate of dues paid by them during the year in which they entered service.

5. Advertising Standards in *The Wisconsin Medical Journal*

After discussion by Councilors Fitzgerald, Gavin, Hough, Christofferson, Dr. Olin West, and Secretary Crownhart of this order of business, upon motion of President Kurten, seconded by Councilor Hough, the Council voted not to accept the advertising of whiskey in *The Wisconsin Medical Journal.*

6. Report of the Auditing Committee of the Council

Chairman Gavin called upon Dr. H. H. Christofferson, Colby, to present the report of the Auditing Committee, of which he is chairman. Dr. Christofferson reported as follows:

"The Auditing Committee of the Council is composed of Drs. H. H. Christofferson, Colby, chairman; G. W. Krahn, Oconto Falls; and Dr. C. W. Eberbach, Milwaukee. During 1943, Dr. Charles E. Pechous of Kenosha served as a fourth member of

the committee. Drs. Christofferson, Eberbach, and Pechous met in the offices of the State Medical Society of Wisconsin on Monday, August 23, 1943, and received the report of the auditor for the Society as it relates to the secretary's receipts and disbursements, and the treasurer's account, including *The Wisconsin Medical Journal* and the financial affairs of the Society. Pursuant to custom earlier established, a detailed examination was made of the individual itemized vouchers for the year 1942, and the committee reports that the voucher for each bill paid was properly itemized and allocated and supported the check issued.

"The committee examined the financial records of the Society and found all in order. Actual inspection was made of the bonds of the Society in safekeeping at The First National Bank of Madison, and they were found to be properly reported in the treasurer's account.

"The committee is pleased to report that the budget expenditures and allocations total $53,438.42, against an income available for current expenses of $59,702.12. This income was from dues and assessments and was augmented by interest on investment securities of $1,000.16 and interest on insurance proceeds left on deposit of $183.96. These latter two items were properly allocated to the reserve of the Society, and this total income of $60,886.24 is exclusive of funds received as revenues in connection with the annual meeting, postgraduate centers, or as reimbursement to the Society for miscellaneous items such as reprints of articles appearing in *The Wisconsin Medical Journal.* Income from these sources was allocated to the proper budgetary items as revolving funds. The Auditing Committee is able to report that the budget estimate prepared in January, 1942, was substantially fulfilled throughout the year 1942.

"At the close of 1942, the Society was possessed of reserve funds as follows:

1. Securities owned, face value	$32,000.00
N. B.—Actual market value at the close of 1942: $32,934.65.	
2. Interest on investment securities	1,000.12
3. Principal received on insurance proceeds (1942)	1,004.88
4. Interest on insurance proceeds left on deposit with insurance company	183.96
5. Value of insurance policy on deposit	8,453.20
Total	$42,642.16

"In addition, the Society had a free cash excess for the year of $6,263.70, of which $4,000 was allocated to the reserve of the Society by Council action taken at its annual meeting in January. The balance of $2,263.70 is thus held in the operating account as a contingent reserve pending further experience in 1943. It may be said, therefore, that the actual reserve of the Society, as of the close of 1942, totalled $46,642.16. This is still less than the proper wishes of the treasurer and the secretary, confirmed by the Council on repeated occasions, that the ultimate reserve of the Society should total not less than the normal dues income for a calendar year.

"The Auditing Committee commends the treasurer for the careful attention he has given the Society's investments and commends the officers of the Society for the manner in which the accounting procedures are followed and the safeguards that have been devised to assure all reasonable protection to the Society disbursements. It reports a completely satisfactory financial review for the year 1942.

THE AUDITING COMMITTEE OF THE COUNCIL
H. H. CHRISTOFFERSON, M. D., Colby, *Chairman*
G. W. KRAHN, M. D., Oconto Falls
C. W. EBERBACH, M. D., Milwaukee
C. E. PECHOUS, M. D., Kenosha."

It was moved by Councilors Pippin–Fitzgerald that the Auditing Committee's report be accepted, and it was voted unanimously so to do.

7. Report of the Committee on Maternal and Child Welfare

The assistant secretary read the supplementary report of the Committee on Maternal and Child Welfare. Councilor Pechous informed the Council that the members of the Kenosha County Medical Society were opposed to accepting any money from the federal government for obstetric care for the wives of servicemen. Chairman Gavin called upon Dr. Neupert, State Health Officer, to explain some of the background of the Emergency Maternal and Infant Care program. Extensive discussion of the subject was participated in by Councilors Pechous, Christofferson, Gavin, Fitzgerald, Hough, Clark, President Kurten, Dr. Olin West, Dr. Neupert, Secretary Crownhart, and Assistant Secretary Larson.

Upon motion of Councilors Fitzgerald–Pechous, it was voted to refer the committee's report to the House of Delegates.

8. Introduction of Guests

At this point in the proceedings, Chairman Gavin introduced to the councilors the many distinguished guests present at the meeting.

9. Report of the Committee on Medical Economics and Voluntary Sickness Insurance

In accordance with specific House of Delegates direction, the Committee on Medical Economics and Voluntary Sickness Insurance placed before the Council for its action a proposal for further experimentation in the field of voluntary sickness insurance. The detailed report of the committee, having previously been submitted to the Council, was before it for consideration. During the consideration of this order of business, the chairman of the committee, Dr. D. H. Witte, submitted a minority report. After extensive discussion by virtually all members of the Council, the secretary advised that the hour for dinner having arrived, it would be necessary to recess the meeting and establish a reconvening time. This was set at 10:30 p. m.

RECESS

After extensive discussion upon reconvening, it was moved by Councilors Hough–Leahy that the following portion of the minority report be adopted:

> "1. That all x-ray, laboratory and anesthesia coverage be eliminated from the plan, at least for a trial period . . . "

Secretary Crownhart then stated: "I think the question is now whether the Council desires to authorize the Committee on Medical Economics and Voluntary Sickness Insurance and the secretary's office to proceed with the perfection of this plan and its mechanical details, and to operate the same as the House of Delegates has indicated these plans

should be operated. So that there won't be any misunderstanding, the House in 1940 said control should be vested in the State Medical Society, assuming cooperation of that body with any county medical society."

Thereafter, Councilor Arveson made the following motion: "I make the motion that the plan be approved following action of the House of Delegates in 1940." The motion was seconded by Councilor Hough and carried.

10. The Council on Scientific Work

Assistant Secretary Larson informed the Council that the Council on Scientific Work had asked that out-of-state speakers appearing on the scientific program of the anniversary sessions be given longer than twenty minutes for the presentation of their papers. Upon motion of Christofferson–Leahy, it was voted to recommend to the House of Delegates that the By-laws be amended to grant out-of-state speakers a maximum of thirty minutes.

Secretary Crownhart informed the Council that its approval was sought by the Council on Scientific Work of the following procedure: The various section chairmen, after planning their respective programs, would submit them to the Council on Scientific Work, which, in turn, would extend the invitation to the speakers to participate. It is felt that such a procedure would eliminate much of the confusion and delay in the preparation of the scientific program for the annual meeting. The Council voted to extend this approval.

11. Adjournment

After announcements by Chairman Gavin and Secretary Crownhart, the meeting adjourned at 11:35 p. m.

C. H. Crownhart
Secretary

Approved:
S. E. Gavin, M. D.
Chairman of the Council

Minutes of the Council, Madison, November 14, 1943

1. Call to Order

The Council was called to order by the chairman at 9:00 a. m., Sunday, November 14, at the Madison Club, Madison.

2. Roll Call

The following were present, constituting a quorum: Councilors Gavin, chairman; Hough, Pechous, Vingom, Spiegelberg, Heidner, Jegi, Krahn, Christofferson, Arveson, Ekblad, Eberbach, Fitzgerald, Blumenthal, and Past-president Gundersen. Councilor Leahy was unable to be present. Officers and guests present were President R. M. Kurten, President-elect Charles Fidler, Treasurer I. R. Sisk, Speaker of the House of Delegates P. R. Minahan, Delegates to the American Medical Association W. D. Stovall and A. E. Rector; secretary of the State Board of Medical Examiners and chairman, Committee on Public Policy, C. A. Dawson; state health officer, C. N. Neupert; Mr. C. H. Crownhart and Mr. G. B. Larson, secretary and assistant secretary, respectively, the State Medical Society of Wisconsin.

Chairman Gavin introduced the two new members of the Council, C. O. Vingom, Madison, and E. H. Spiegelberg, Boscobel, representing the Third and Fourth Districts, respectively.

3. Minutes of September Council Meeting

Because the minutes of the September Council meeting would not be published until the December issue of *The Wisconsin Medical Journal*, approval was withheld until the January meeting of the Council.

4. Compensability of Hernia

Dr. Gunnar Gundersen, as chairman of the Committee on Industrial Health, presented a report for his committee on the subject of compensability of hernia. General discussion of the subject followed, participated in by Councilors Pechous, Ekblad, Vingom, Gavin, Past-president Gundersen, President Kurten and Assistant Secretary Larson. The matter was left open for further study and report.

5. Contraceptive Advertising, *The Wisconsin Medical Journal*

Assistant Secretary Larson presented the matter of acceptance of certain contraceptive advertising in *The Wisconsin Medical Journal* and for exhibit purposes at the Annual Meeting of the Society in view of the fact that products of this nature of certain companies now have been approved by the American Medical Association for advertising purposes. The Council voted not to accept contraceptive advertising or exhibits at this time.

6. Resolution re Wagner–Murray–Dingell Bill

With many state medical societies and county societies now adopting formal resolutions relative to the Wagner–Murray–Dingell bill, it was suggested that the Council should now take such action on behalf of the State Medical Society of Wisconsin. There was discussion by Secretary Crownhart, Councilors Heidner, Gavin and Hough, after which, upon motion by Councilors Heidner–Blumenthal, the chairman was authorized to appoint a committee for the purpose of drafting and editing such a resolution in behalf of the Council. Chairman Gavin then appointed Councilors Hough, Vingom and Eberbach to this committee, with instructions to proceed at once with the project.

Bind or place

Remove and place on your desk, or other convenient place, for ready reference.

Rules for Determining Compensability of Hernia Under the Wisconsin Workmen's Compensation Act

Under the Wisconsin Compensation Act, hernias may be compensated either on the basis of accidental or gradual occupational origin.

ACCIDENTAL HERNIA

In order to establish *accidental* hernia, the commission has laid down the following rules, approved by the Supreme Court, in the case of *Meade v. Ind. Comm.* 168 Wis. 250.

1. **The accident must be such as could produce a hernia;**
2. **The hernia must appear immediately after the accident;**
3. **It must be followed by pain immediately disabling the applicant;**
4. **The applicant must give immediate notice of injury to the respondent.**

The commission has concluded that unless these rules are reasonably met, it is speculative to assign causation of hernia to work on an accidental basis. The word "immediately" is to be construed reasonably in the light of all circumstances.

GRADUAL HERNIA

To prove hernia as the result of *gradual* process on an occupational basis, it must be shown:

1. **That the work was of a character such as to produce intra-abdominal pressure of sufficient severity and over a sufficient period of time to result in hernial protrusion.**
2. **Other causes not resulting from work must be reasonably excluded, such as continued cough, constipation, or activities apart from work which produce intra-abdominal pressure.**

The fact of a preexisting weakness does not exclude a finding of occupational causation. A hernia which actually existed prior to the time of employment will not be attributed to subsequent employment, although strangulation of a preexisting hernia may be held compensable.

Prepared at request of
State Medical Society of Wisconsin
by
Mr. Harry A. Nelson, Director,
Workmen's Compensation Division
Wisconsin Industrial Commission

7. Classification of Office Staff

Secretary Crownhart presented the problem encountered in stabilizing the office staff of the secretary's office under present wage and hour limitations, presented a report including suggested minimum and maximum limitations during the war emergency, and asked authorization of the Council for stabilizing the office staff on such a basis. There was discussion by Councilors Heidner, Fitzgerald, Blumenthal, Gavin, President Kurten, Delegate Rector and Secretary Crownhart. The secretary was then instructed to proceed with a classification of the office staff in accordance with his report.

8. Resolution Adopted by Past-presidents at Annual Meeting

Past-president Gundersen read and discussed a resolution adopted at the Past-presidents' Luncheon during the Annual Meeting of the Society in September, which pertained to activities of the secretary of the Society in broadening his field and scope of study concerning problems of the day in the medico-economic and other fields. Councilor Arveson enlarged upon the remarks of Dr. Gundersen, and general discussion was participated in by Councilors Heidner, Arveson, Gavin, Ekblad and Christofferson, President Kurten, and Past-president Gundersen. The resolution referred to reads as follows:

"WHEREAS, Our secretary, C. H. Crownhart, appears to be burdened unnecessarily with office detail and matters of a routine nature to such a degree that it is difficult for him to give to the Society his considered viewpoint as it relates to trends bearing on the general subject of the Delivery of Medical Service;

"*Now, therefore, be it resolved:*

"1. That the secretary be encouraged to travel and to ascertain by firsthand investigation through conference with men in high places, thereby securing their attitude toward the practice of medicine; that inasmuch as much activity may involve extensive travel, he be furnished with sufficient expense money for such travel;

"2. That he be given sufficient time to carry on studies, without interruption, of medical journals and other subject matter to the end that he can act as a clearing house for medical thought as it exists in other states and in the nation and world at large;

"3. That he be instructed to pay particular attention to the function of acting as liaison officer to the new Council on Medical Service and Public Relations, recently created by the House of Delegates of the American Medical Association, to the end that the State Medical Society of Wisconsin will be in a position to give its wholehearted and enlightened support to the new Council and its director.

"4. That the information so gathered by the secretary and the conclusions reached by such study be made available to the profession."

Upon motion by Councilor Ekblad, variously seconded, the secretary was instructed to study the resolution and to formulate a program based thereon for presentation at the January, 1944, meeting of the Council. Motion carried.

9. Dates of 1944 Annual Meeting

President Kurten explained a proposal that the Annual Meeting of the Society be moved forward from September to May in 1944, after which Assistant Secretary Larson presented points for and against such a change in meeting dates. Discussion was participated in generally, and upon motion by Councilors Hough–Jegi, and carried, it was determined to retain September as the month for the Annual Meeting of the Society in 1944.

10. Circulation of *The Wisconsin Medical Journal*

Secretary Crownhart discussed the matter of distribution of the Wisconsin Medical Journal to members of groups practicing the healing arts other than the medical profession and the problems encountered. Upon motion by Councilors Heidner–Pechous, and carried, it was the decision of the Council to accept the secretary's proposal to restrict distribution of *The Wisconsin Medical Journal* among those engaged in the field of treating the sick to members of the American Medical Association.

Secretary Crownhart then made announcements, including the fact that all councilors customarily are called upon at the annual business meeting of the Council in January for a report on conditions in the individual councilor districts. A recess was then taken from 11:05 until 11:15 a. m.

11. Report on the Procurement and Assignment Service

Chairman Gavin called upon Dr. R. E. Fitzgerald, state chairman for the Procurement and Assignment Service for Physicians, who then gave a report of recent developments in that field and discussed specific situations which have developed in and about the state in the individual councilor districts. Special emphasis was placed by Doctor Fitzgerald upon the nine months medical education program and the apportionment of interns and residents to hospitals in Wisconsin.

12. Voluntary Sickness Insurance Plan Proposed for Milwaukee

At this point, representatives of the Medical Society of Milwaukee County joined the Council. These were Eben J. Carey, president; John McCabe, president-elect; and Mr. James O. Kelley, executive secretary of that society. Dr. Dexter H. Witte, chairman of the State Medical Society's Committee on Medical Economics and Voluntary Sickness Insurance, also was present at this time. Secretary Crownhart presented, chronologically, the background of the proposed plan as it related to the State Medical Society and discussed a mimeographed chart which had been distributed among the councilors outlining suggestions for management of that plan. At 12:15 p. m. a recess was taken for dinner, after which, at 1:50 p. m. the meeting was resumed with discussion of this order of business.

It was moved by Past-president Gundersen, in order to crystalize discussion, that the Council give its

approval to the plan as outlined by the secretary. The motion was seconded by Councilors Arveson and Jegi. Presentation of the problem involved application of the regulation established by the House of Delegates in 1940 that any further experimentation in voluntary sickness insurance by the medical profession as such should be operated only by the State Medical Society. The secretary's proposal called for the creation of a Directing Board to be composed of the president of the Society, two members of the Committee on Medical Economics and Voluntary Sickness Insurance, one member of the Council, and the chairman of the Medical Extension Committee of the Medical Society of Milwaukee County. It was proposed, in substance, that the Directing Board would serve in a general directing capacity, with a local Executive Committee to function in each community in which such a plan of voluntary sickness insurance might be established.

Long and comprehensive discussion followed, participated in by all present, and including reports by Dr. Witte as chairman of the Committee on Medical Economics and Voluntary Sickness Insurance, Doctors C. O. Vingom, Eben J. Carey, John McCabe and R. G. Arveson. The substance of the request made by those representing the Medical Society of Milwaukee County was to the effect that the action of the House of Delegates in 1940 be waived in this instance so that entire management might be vested in the local county medical society, with the understanding that should other plans of similar character be established elsewhere, management of the Milwaukee proposal would be returned to the State Medical Society.

At this point, Past-president Gundersen withdrew his former motion with consent of the second, Councilor Arveson. Past-president Gundersen then moved, and Councilor Jegi seconded, "That the proposed Milwaukee County plan be operated on a trial basis for one year and that the board of directors of the Medical Society of Milwaukee County be appointed as a committee of the Council of the State Medical Society of Wisconsin to supervise and operate the plan for and on behalf of the Council of the State Medical Society, only for so long as the plan pertains to the Pressed Steel Tank Company of Milwaukee."

Representatives of the Medical Society of Milwaukee County expressed their approval of the motion proposed, stating that it would meet with the acceptance of their county society. They also stated that further proposals within the county, if such should be made, would be referred to the State Medical Society in keeping with established procedures. The motion by Councilors Gundersen–Jegi was then put and unanimously carried. It was specifically understood, following discussion by Doctors Krahn, Christofferson, Pechous, Eberbach, Carey, Gavin, Hough, Ekblad, Gundersen, Fidler, Secretary Crownhart, Assistant Secretary Larson and Mr. Kelley, that statistical information and reports would be available to the Council at any time called for after the plan began operation.

The meeting adjourned at 4:00 p. m.

Society Proceedings

Brown—Kewaunee—Door

A dinner and business meeting of the Brown–Kewaunee–Door County Medical Society was held at the Beaumont Hotel, Green Bay, on November 18. The speaker at the meeting was Dr. M. G. Peterman of Milwaukee whose subject was "The Care of the Premature Infant."

Chippewa

Dr. James B. Carey of Minneapolis spoke at the meeting of the Chippewa County Medical Society on November 9 at Hotel Northern, Chippewa Falls. The topic of his discussion was "Changes in the Gastric Mucosa Related to Disease."

Dane

The regular monthly meeting of the Dane County Medical Society was held Tuesday, November 16, at the Madison Club, Madison. The program included a talk by Dr. John B. Barnwell, associate professor of internal medicine, University of Michigan Medical School, Ann Arbor, Michigan, on "An Experience in the Control of Tuberculosis in a General Hospital," and a talk by Dr. Leroy U. Garner, Director of The Saranac Laboratory for the Study of Tuberculosis, Saranac Lake, New York, on "Tuberculosis in Industry."

Dodge

The annual meeting for the election of officers was held by the Dodge County Medical Society at the Rogers Hotel, Beaver Dam, October 21. Those elected to hold office for the coming year were:

President—Dr. Peter F. Langenfeld, Theresa
Vice-president—Dr. W. H. Costello, Beaver Dam
Secretary-Treasurer—Dr. A. M. Rosenheimer, Beaver Dam
Delegate—Dr. Francis G. Bachhuber, Mayville
Alternate Delegate—Dr. E. S. Elliott, Fox Lake
Censor—Dr. Xavier Corso, (3 years), Beaver Dam

The matter of the Blue Cross Hospital plan for physicians, their families and office assistants was discussed, and it was decided that the secretary of the society should take charge of all correspondence relating thereto.

There were no speakers at this meeting of the society.

Eau Claire—Dunn—Pepin

Dr. George S. Kilkenny and Dr. Samuel Rosenthal, both of Marquette University, Milwaukee, were the speakers at the October 25 meeting of the Eau Claire–Dunn–Pepin County Medical Society which was held at Hotel Eau Claire, Eau Claire. Dr. Kilkenny spoke on "Diabetes in Pregnancy," and Dr. Rosenthal on "Acidosis, Alcoholosis and Water Balance in General Practice."

The annual election of officers was also held at this meeting:

President—Dr. E. P. Hayes, Eau Claire
Vice-president—Dr. H. M. Stang, Eau Claire
Secretary–Treasurer—Dr. H. C. Huston, Eau Claire
Delegate—Dr. F. G. Anderson, Eau Claire
Alternate Delegate—Dr. B. F. Johnson, Mondovi
Censor—Dr. F. S. Cook, Eau Claire

Grant

The Grant County Medical Society held its annual business meeting in Lancaster at the Grantland, October 28. Officers elected for the coming year were:

President—Dr. H. W. Carey, Lancaster
Vice-president—Dr. F. A. Soles, Platteville
Secretary–Treasurer—Dr. H. L. Doeringsfeld, Platteville
Delegate—Dr. J. H. Fowler, Lancaster

At the afternoon session of the meeting, Doctors W. D. Stovall, L. W. Paul, and O. O. Meyer, all of the University of Wisconsin Medical School, Madison, were the principal speakers. Dr. H. M. Coon, superintendent of the Wisconsin General Hospital, Madison, addressed the group in the evening.

Jefferson

Dr. Herman W. Wirka, Wisconsin General Hospital, Madison, addressed the meeting of the Jefferson County Medical Society on October 21 at Watertown. Dr. Wirka's topic was "The Kenny Treatment of Poliomyelitis."

La Crosse

The La Crosse County Medical Society met at the Stoddard Hotel in La Crosse on November 9. The speaker of the evening was Dr. Wallace E. Herrel of the Mayo Clinic, Rochester, whose subject was "Penicillin."

Marathon

A business meeting, with election of officers, was held by the Marathon County Medical Society at the Wausau Hotel, Wausau, November 4. Those physicians, all of Wausau, chosen to hold office for the coming year were:

President—Dr. R. H. Juers
President-elect—Dr. H. H. Christensen
Secretary-Treasurer—Dr. H. H. Fechtner
Delegate—Dr. J. F. Smith
Alternate Delegate—Dr. E. E. Flemming
Program Committee—Drs. J. F. Smith, M. L. Jones, and G. H. Stevens
Censors—Drs. J. J. Burby, P. Z. Reist, and A. H. Stahmer
Legislative and Public Health Committee—Drs. W. C. Frenzel, H. R. Fehland and F. H. Frey

Racine

The Racine County Medical Society held its regular meeting for the month of November on the eighteenth at the Elks Club in Racine.

Rock

Major John Chornyak, Truax Field, Madison, spoke to the meeting of the Rock County Medical Society at the Monterey Hotel at Janesville on October 26. His subject was "Constitutional Psychopathic States and Maladjustments to Army Life." He was accompanied by Major C. S. Higley and two other officers from the medical center. A film on blood plasma was also included in the program.

Election of officers for the coming year took place at this meeting with the following physicians being chosen:

President—Dr. O. V. Overton, Janesville
Vice-president—Dr. Thomas Flarity, Beloit
Secretary–Treasurer—Dr. C. M. Carney, Beloit

The November meeting of the society was held at the Hotel Hilton in Beloit on Tuesday, November 23. Dr. O. V. Overton assumed the presidency at this meeting, and the speaker of the evening was Mr. W. L. Jackman, Madison attorney, who spoke on "Avoidance of Malpractice Litigation."

Sheboygan

The Sheboygan Memorial Hospital, Sheboygan, was the scene of the October 28 meeting of the Sheboygan County Medical Society. Dr. Herman W. Wirka, Madison, spoke to the society on "The Evaluation of the Kenny Treatment of Poliomyelitis." He discussed the disease, particularly as seen at the Children's Orthopedic Hospital, a section of the Wisconsin General Hospital, Madison.

Trempealeau—Jackson—Buffalo

The October meeting of the Trempealeau–Jackson–Buffalo County Medical Society took place at Fountain City on October 21. Dr. James C. Fox of La Crosse presented a paper on "Erythroblastosis Fetalis," and Dr. E. E. Seedorf, La Crosse, showed a number of X-ray pictures on gastrointestinal and bone disorders.

At the November meeting of the society, which took place on the twelfth, Dr. Erwin R. Schmidt, professor of surgery at the University of Wisconsin Medical School, discussed "Carcinoma." Dr. Schmidt

stated that there are from 17 to 20 cases of this disease treated at the university hospital each year.

Walworth

Both the Walworth County Medical Society and its auxiliary held a supper meeting at the Delavan Hotel on October 21. Following the banquet, the two groups held individual business meetings.

Winnebago

At their meeting on November 11 members of the Winnebago County Medical Society heard Dr. G. L. Bellis of the Sunnyview Sanatorium, Winnebago, speak on "Newer Conceptions in Tuberculosis." Dr. Bellis also presented case reports. The meeting was held at the sanatorium.

News Items and Personals

Pan American Health Day was celebrated at the University of Wisconsin on Thursday, November 18. Speakers on the program were two distinguished South American lecturers: Dr. Estencio Hormaeche, Assistant Director of the Institute of Infectious Diseases, Montivedeo, and Professor of Bacteriology, University of Montivedeo, whose subject was "Etiology of Infantile Summer Diarrhea, with Special Reference to Salmonella Infection"; and Dr. Alfredo Sordelli, Director of the Argentina National Institute of Health. Dr. Sordelli's subject was "Diphtheria." The program was held in the Auditorium of Service Memorial Institute.

As we all know, Pan American Health Day in the United States is celebrated annually on December 2, by Proclamation of the President of the United States. It is a day set aside to recognize almost four decades of Pan American cooperation in public health and to continue interest in this endeavor.

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On the program of the October meeting of the Milwaukee Neuro-Psychiatric Society held at the University Club, were *Doctors Lewis Danziger, H. T. Schroeder*, and *A. A. Unger*, all of Milwaukee. The subject of their speeches was "Sex Hormone Therapy in Involutional Melancholia."

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Dr. J. D. Walsh, practicing physician at Muscoda, recently left for the University of Pennsylvania, where he will take special training in ophthalmology. *Dr. Emmett T. Ackerman*, Gays Mills, who has been located in that village for almost twelve years, has taken over Dr. Walsh's practice at Muscoda. The two physicians were classmates at the University of Wisconsin.

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The last class in a series of three postgraduate education courses on respiratory diseases, which were sponsored by the Medical Society of Milwaukee County for members of the medical profession at Marquette University, was held November 9. "Surgical Aspects of the Respiratory System" was the subject presented by Dr. Willard Van Hazel, associate professor of surgery at the University of Illinois College of Medicine, and *Doctors John D. Steele, A. A. Schaefer* and *Joseph M. King*, all of Milwaukee.

Instruments valued at $24 were stolen recently from the office of *Dr. S. C. Allen*, Waterloo physician. The thief was apparently familiar with the local situation, as he later appeared at another professional office in Waterloo where he attempted to sell some of the instruments. By the time Dr. Allen had missed the instruments, the thief had left town.

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Dr. B. J. Hughes, Superintendent of the Northern State Hospital at Winnebago, gave a talk on "Mental Diseases" at a dinner meeting of the Allouez assembly, fourth degree Knights of Columbus, at Appleton on Thursday, October 28.

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Dr. W. D. Stovall, Director of the Wisconsin State Laboratory of Hygiene, Madison, was elected Secretary of the State Board of Public Welfare at the meeting of the board on Tuesday, November 9.

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The Marshfield Business and Professional Women's Club had as speaker at their regular October meeting *Dr. Stephen A. Epstein*, a member of the Marshfield Clinic. To quote from the *Marshfield Journal* of October 28, 1943, Dr. Epstein brought out the following theme in his talk: "The price of peace is the surrender of a part of our individual sovereignty. We know now what we are paying for war and we must consider the price of peace. Unless the issue is faced now, we may again find that too little was paid too late. There is no compromise between peace and war."

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From the University of Wisconsin Medical School Activities Bulletin comes the following announcements:

A new course in Occupational Therapy is offered, under the direction of *Dr. Frances Hellebrandt*, which has been made a section of the Department of Medicine.

The Medical School, at the request of the Office of Civilian Defense, has organized a team to present the various aspects of chemical warfare to physician groups throughout this area. *Drs. J. A. E. Eyster*, and *A. R. Curreri* have already presented their program at eight centers and are well satisfied with the interest and response of the physicians.

Dr. W. E. Sullivan of the Section on Anatomy at the University Medical School reports the initiation

of studies on the Vertebral Column and the completion of an X-ray Study of the Thorax.

From the Department of Bacteriology comes the news that *Dr. F. A. Holford* has returned from a two months course in tropical medicine at the Army Medical School at Washington. Dr. Holford reported the course a stimulating and valuable experience.

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The Milwaukee Surgical Society held its November meeting Monday, November 1, at the University Club. Dr. Herbert Schmidt, Chicago, who discussed "The Treatment of Uterine Carcinoma," was the principal speaker of the evening. A case of "Stone in the Common Duct" was presented by *Dr. Carl Eberbach*, Milwaukee.

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Dr. L. E. Rauchschwalbe of Wauzeka, who is a graduate of Loyola University of Chicago, is now practicing medicine and surgery with *Dr. G. W. Krahn* at the latter's office at Oconto Falls.

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On Wednesday, November 17, the Wisconsin Academy of Surgery presented the following program at a dinner meeting at the University Club in Milwaukee: "The Use of the Padgett–Hood Dermatome," by *Dr. Leslie W. Tasche*, Sheboygan; Discussion by *Dr. G. V. I. Brown*, Milwaukee. "Tumors of the Parathyroid Gland," by *Dr. Russell M. Kurten*, Racine; Discussion by *Dr. T. J. Snodgrass*, Janesville. "Hypoparathyroidism," by *Dr. W. J. Carson*, Milwaukee. "The Use of Amniotic Fluid Concentrate in Pelvic Surgery," by *Dr. Harold R. Fehland*, Wausau; Discussion by *Dr. J. J. Adamkiewicz*, Milwaukee.

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Dr. Mina B. Glasier, who has practiced medicine at Bloomington for sixty years, was 84 years old November 5. Dr. Glasier practiced with her husband, *Dr. W. H. Glasier*, for nearly twenty years until his death in 1900. Dr. Glasier was secretary of the Grant County Medical Society for thirty years and president for one, was a member of the State Board of Health for fourteen years, received an award for distinguished service from the State Medical Society of Wisconsin in 1932, was made a life member in 1933, and an honorary member in 1934. Dr. Glasier recently retired from active practice.

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Dr. Robert K. Irvine and his father, *Dr. Wesley J. Irvine*, practicing physicians of Manawa, have purchased the Crowley store building in that town, which they will convert into an office and clinic.

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The Milwaukee Oto-Ophthalmic Society held its first meeting of the season on Tuesday evening, November 9, at the University Club in that city. The scientific program was conducted by Dr. Louis Hoffman, Clinical Professor of Ophthalmology, Loyola University, Chicago, Illinois, whose subject was "Chronic Glaucoma—Indications for and Choice of Operation." Dr. Hoffman demonstrated the technic of the operations with colored motion pictures.

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Dr. George N. Pratt, Jr. was recently appointed city physician at Menasha to replace *Dr. William B. Hildebrand*, who entered the armed forces. The appointment is subject to Dr. Pratt's acceptance.

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Attending the fall meeting of the Wisconsin Society of Obstetrics and Gynecology at Milwaukee on Wednesday, November 10, was *Dr. James B. Vedder*, Marshfield. The meeting, according to Dr. Vedder, centered around the report of a special committee on caudal anesthesia. Dr. Vedder reported that the committee advised against the continuous use of caudal anesthesia over a period of hours and asked a year's time before giving an opinion on the use of a single caudal injection.

In connection with the meeting, a program was presented at the Marquette University School of Medicine, under the direction of *Dr. Eben J. Carey*, dean of the school, which included an exhibit on "Anatomy as Related to Caudal Anesthesia."

One of the speakers at the meeting was *Lieutenant Commander Malcolm H. Hipke, M. C., USNR*, a nephew of *Dr. William Hipke* of Marshfield. Commander Hipke, who is Indoctrination Officer of the Naval Training School (Women's Reserve) at the University of Wisconsin, Madison, reviewed "Health Problems of Women in Service."

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Dr. Eben J. Carey, dean of the Marquette University School of Medicine, spoke to the Milwaukee County Pharmacists Association and the Sunday Morning Breakfast Club at the Red Arrow Club on November 7. The theme of Dr. Carey's speech was that much of the "propaganda" urging subsidized medical care is financed by foreign interests.

Dr. Marcos Fernan–Nunez, professor of pathology and bacteriology at the Marquette University School of Medicine, was made an honorary member of the Pharmacists Association at this meeting for his work in tropical diseases.

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October 12, 1943, marked fifty years of medical practice for *Dr. Clark C. Post* at Barron. Dr. Post, an associate of the Barron Clinic, came to that city on October 12, 1893, from Chicago. In 1901, Dr. Post and his brother-in-law, *Dr. H. M. Coleman*, established the Barron Hospital, of which the Barron Clinic is an outgrowth. Dr. Post served in the medical corps of World War I as a captain at Camp A. A. Humphrey, Washington, D. C., and is at present examining physician for Barron County selectees. He is an 1893 graduate of the Chicago College of Physicians and Surgeons, now one of the colleges of the University of Illinois.

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Dr. Albert C. Schmidt, chief of the Orthopedic Department of Milwaukee Children's Hospital, told the Section on Education for Crippled Children of the Wisconsin Education Association on Thursday

afternoon, November 4, that poliomyelitis cases were not numerous in Wisconsin and Milwaukee this year, but the disease frequently recurs in the same area two successive years. Dr. Schmidt reported that the death rate in paralysis cases is now about 10 per cent, an increase of 4 per cent over the death rate of the previous ten years.

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Village and township health officers of Rock County met on Wednesday, November 17, for their annual session. *Dr. Margaret E. Hatfield*, Janesville, is director of the county sanitary unit. Highlights of the program, arranged in cooperation with *Dr. Fred B. Welch* of the Janesville Health Department, included addresses by *Dr. Joseph C. Springberg*, Beloit city health officer, and H. W. Brown, bacteriologist from the State Laboratory of Hygiene.

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Dr. Robert W. Shaw, Marinette, and *Dr. Alexander J. Bosse*, Ableman, who were recently discharged from the Army Medical Service, are again practicing in their respective cities.

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Dr. H. E. Perrin, Star Prairie, began his fiftieth year of general medical practice in October. Dr. Perrin has given medical service to the people of Star Prairie and residents of the vicinity since 1894, when he received his degree from Northwestern University.

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The theme of a talk given at the First Baptist Church, Madison, on Wednesday, October 27, by *Dr. Annette C. Washburne*, professor of neuropsychiatry at the University of Wisconsin Medical School, Madison, was "Religion in Relation to Mental Health." Dr. Washburne asserted in her speech that a person lacks awareness when his spiritual side is undeveloped. She also stated that when he lacks perception, he seems unable to penetrate into the value of things and cannot adjust himself to his proper sphere.

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A recent appointee to the staff of the Jackson Clinic, Madison, is *Captain Earl A. Doersch*, former Portage physician, who has retired from active duty in the Army Medical Corps. Dr. Doersch has established residence in Shorewood Hills.

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At the October meeting of the council of the Village of Frederic, *Dr. R. G. Arveson*, pioneer physician, mayor and leading citizen, presented the village with a deed to his beautiful home. It was stipulated in the deed that the house be used as a library or other public community project. The doctor and his wife may occupy the residence during his lifetime, but all taxes and maintenance will be paid by him.

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In a radio broadcast over Station WHA Friday, November 19, *Dr. Llwellyn R. Cole*, director of the student health service at the University of Wisconsin, Madison, discussed "The Common Cold." Dr. Cole's address was sponsored by the Visiting Nurse Association of Madison.

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Dr. Loran W. Beebe, Superior, was elected president of the St. Joseph's hospital medical staff at Superior at the annual election meeting on Thursday, November 11. Other officers elected were *Drs. E. A. Myers* and *Richard P. Fruehauf* as vice president and secretary-treasurer, respectively.

SOCIETY RECORDS

New Members

Philip M. Cornwell, 1300 University Avenue, Madison 6.

Angie Connors, 1300 University Avenue, Madison 6.

R. R. Benson, 1300 University Avenue, Madison 6.

M. G. Radewan, 1300 University Avenue, Madison 6.

J. M. Wilson, 1300 University Avenue, Madison 6.

C. K. Ziegler, 3430 West Vliet, Milwaukee.

M. R. Markson, 531 West Wisconsin Avenue, Milwaukee.

L. M. Knox, 5330 North Bay Ridge, Milwaukee.

Changes of Address

J. P. Skroch, Arcadia, to La Siesta Court, Cosa Grande, Arizona.

L. E. Rauchschwalbe, Wauzeka, to Oconto Falls.

E. T. Ackerman, Gays Mills, to Muscoda.

C. A. Armstrong, Prairie du Chien, to Dousman.

COMING EVENTS

Sixth Annual Forum on Allergy

The Statler Hotel, St. Louis, will be the location of the Sixth Annual Forum on Allergy on Saturday and Sunday, January 22 and 23, 1944. This is a meeting to which all physicians are welcome, at which they will be offered an opportunity to bring themselves up to date in this rapidly advancing branch of medicine at two days of intensive postgraduate instruction. There will be fifteen study groups, any three of which are open to the physician, and they will be so divided that those dealing with Ophthalmology, Otolaryngology, Pediatrics, Internal Medicine, Dermatology and Allergy will run consecutively. Also, the study groups will be arranged on the basis of previous registration. In this way, the registrant will have a chance to write the group leader suggesting just what questions he wants brought up in the discussion. Almost every type of instructional method will be employed at the Forum. Special lectures by outstanding authorities, pictures, demonstrations, symposia and panel discussions will be as important a part of the program as will the study groups.

DECEMBER... the star of Bethlehem and the bombs of Pearl Harbor... the Prince of Peace and the god of war ☆ Christmas will have little meaning to the thousands of physicians who serve their country and perhaps to thousands more who strive to carry on at home. There is little time for exchange of pleasantries in the grim business of winning a war ☆ But the Christmas Season will come again when the forces of evil are dead—when man again will do unto others as he would have done unto him.

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BIRTHS

A son, Howard Bruce, to Dr. and Mrs. A. N. Natenshon, Milwaukee, on October 11.

A son to Dr. and Mrs. Joseph A. Rawlins, Elkhorn, on October 26.

A daughter, Mary Elizabeth, to Dr. and Mrs. John G. Van Gemert, Madison, on November 14.

MARRIAGES

Dr. Edward N. Pfeffer, Milwaukee, and Amy Electa Dreyfus, Milwaukee, on October 30 at Milwaukee.

Dr. Sidney K. Wynn, Milwaukee, and Marajen Newman, Beverly Hills, California, on September 19 at Champaign, Illinois.

DEATHS

Dr. John A. Bocella, 30, Milwaukee, died Sunday, October 31, following a long illness. Dr. Bocella was an intern at Milwaukee hospital where he died. Burial was at Pittsburgh, Pennsylvania. Born in Pittsburgh, Dr. Bocella graduated from Duquesne University before coming to Milwaukee to attend the Marquette University School of Medicine. He was a member of the Medical Society of Milwaukee County, the State Medical Society of Wisconsin, and of the American Medical Association.

Dr. Bocella is survived by his widow, his father, three sisters and a brother.

Dr. Harry G. Hinckley, 68, prominent physician and surgeon of Merrill for forty years, died Thursday, November 11, at his home in that city. Burial was at Janesville.

Born in Rochelle, Illinois, on September 12, 1875, Dr. Hinckley was a 1902 graduate of the University of Illinois College of Medicine, at which time he located at Merrill. Dr. Hinckley served his community as chief of staff at the Holy Cross Hospital, as Lincoln County physician, and as health officer for the City of Merrill. He was a member of the Lincoln County Medical Society, the State Medical Society of Wisconsin, and the American Medical Association. Dr. Hinckley was also very active in many other groups and societies in his community.

Survivors include his widow and two daughters.

Dr. William B. Gnagi, 73, Monroe, died Saturday evening, November 6, at the St. Clare Hospital in that city. Funeral services were held at Monroe with burial in the Greenwood Cemetery.

Dr. Gnagi, choosing medicine as his profession, began his medical training at Monroe in 1890 in the office of Drs. N. A. Loofbourow and F. M. Confer previous to entering Rush Medical College in Chicago. Upon his graduation in 1893, Dr. Gnagi practiced at Pullman, Illinois, a suburb of Chicago. There he was city health officer, and in Chicago, as a member of the board of health, he served as special inspector dealing with small pox epidemics. After seven years of medical practice in the Chicago area, Dr. Gnagi returned to Monroe in 1900 to take over the practice of Dr. Confer, his brother-in-law.

Practicing alone until 1927, he was joined by his son, Dr. W. B. Gnagi, Jr., and the Gnagi Clinic was opened at Monroe. Today, the staff of this clinic has enlarged considerably, and it is now known as the Monroe Clinic.

He was city health officer at Monroe from 1902 to 1922 and Green County physician for eighteen years. Dr. Gnagi was also president of the Green County Medical Society for many years, and in 1940 was made a life member of the State Medical Society of Wisconsin. Dr. Gnagi also held membership in the American Medical Association. During World War I, he served as chief medical examiner for the Green County Exemption Board, appointed by Governor E. L. Phillip.

Dr. Gnagi was preceded in death by his wife, who passed away on May 21, 1943. Survivors include four children, three sons and a daughter, and one sister.

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News of the Neighbors

Community Affairs

"Some members of the medical profession may contend that it is not in the realm of medical ethics for individual physicians to take active part in community and civic affairs lest such action be termed advertising.—On the other hand, many assert that the broad and extensive educational training together with the unparalleled every day experiences in human relationships of the physician place him in a duty-bound position to use these advantages in efforts directed toward the betterment of his community." From the "Incidentally" column of the October, 1943, issue of *The Journal of the Missouri State Medical Association.*

Industrial Survey

"The importance of industrial medicine in wartime is generally acknowledged in principle and will be brought home to Minnesota physicians in fact this month when they receive the card questionnaire from the Committee on Industrial Health asking for whole- or part-time volunteers.

"The object of the questionnaire is, first, to find out how many physicians are already serving industry in some capacity; second, to create a pool from which industrial needs all over the state can be met by physicians in private practice on a part- or full-time basis.

"War has provided an impetus to utilization of medicine in industry which is bound to hold over when the peace comes. For industry, it is opening up new avenues to efficient plant operation. For medicine, it affords a sound new method for extension of preventive medicine within the framework of private practice." From the Medical Economics section of the September, 1943, issue of *Minnesota Medicine.*

Blood Plasma

"With the accelerating tempo of the war, the need for blood plasma is constantly increasing. In fact, the demands on the various blood-donor centers of the American Red Cross have become so great that some difficulty in obtaining the required number of donors is being experienced. Just why this is so is difficult to understand, since the total amount of plasma for which any one center is responsible can be obtained from a relatively small percentage of the surrounding population, and certainly the slight sacrifice of time and minor discomfort to the donor are greatly outweighed by the saving of the lives of literally thousands of soldiers and sailors on extended battlefronts.

"It has been said that the medical profession has failed to support the program wholeheartedly, and this statement is based chiefly on the fact that many

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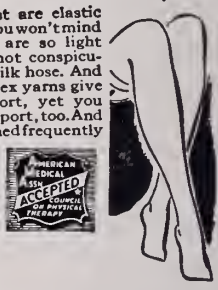

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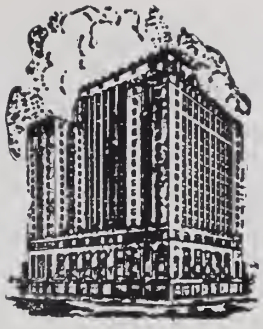
members of a prospective donor group often refuse to give blood, with the excuse that their physicians have advised them against it. Although it is true that a few ultraconservative physicians question the advisability of repeated bleedings on the ground that no one knows the eventual effect, it is difficult to understand how the removal of moderate amounts of blood at adequately spaced intervals in a healthy and active person can do the slightest harm. The healthy professional donor who has given blood for a hundred or more transfusions is no rarity. Furthermore, in those with moderate or severe hypertension or with an excessive amount of blood, as in erythremia, blood-letting at regular periods is an accepted therapeutic procedure. In other words, there seems to be little sound evidence for believing that many of these excuses are founded on fact, but rather are "white lies" prompted by fear and conceived at the moment as the "easiest way out."

"In any event, it behooves physicians to support this worthy program to the utmost. Properly couched statements concerning the value and need of plasma, the care taken at the donor centers to weed out persons who should not give blood and the relative safety and minimal annoyance of the blood-taking procedure will do much to reassure those who are hesitant to do their bit toward the saving of a life." From an editorial in the September 16, 1943, issue of *The New England Journal of Medicine.*

Medical Fees Under Political Control

"The Wagner–Murray–Dingell bill provides that 'Payments from the Trust Fund to general medical practitioners, for services under this title shall be made (A) on the basis of fees for services rendered to individuals entitled to benefits, according to a fee schedule approved by the Surgeon General; or (B) on a per capita basis . . . ; or (C) on a salary basis, whole time or part time; or (D) on a combination or modification of these bases, as the Surgeon General may approve.'

"It seems pertinent, therefore, to estimate, if possible, the value put upon a doctor's services by the federal government. An indication of this may be found in the 1935 volume of the Transactions of the Medical Society of the State of North Carolina, pages 32 to 34. In the minutes of the Executive Committee meeting held on March 9, 1935, at the Sir Walter Hotel in Raleigh, there is recorded the report of a committee appointed to confer with the FERA. (It may be recalled that these letters stood for the Federal Emergency Relief Administration.) The state administrator of this organization had been authorized to have all employables examined. For the purpose an elaborate blank had been prepared, which included a urinalysis and Wassermann test. For making this examination—which all who saw it agreed was equivalent to a regular five-dollar insurance examination—the doctor was to be paid the munificent sum of fifty cents.



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"Dr. McBrayer told the Executive Committee that he asked the administrator if the fifty cents was for the clerical work, and said that he would like to know what the doctor was to get. He was informed that the half dollar would have to pay for professional ability as well as for clerical work. The Executive Committee unanimously voted to decline the offer.

"This tangible evidence of the estimate placed upon medical skill by politicians should strengthen our determination to keep American medicine free from political domination." From an editorial in the September, 1943, issue of *The North Carolina Medical Journal.*

Pressure and the Press

"Some time ago we were apprised of the fact that October with its other bounties would bring out National Newspaper Week, devoted to freedom of the press. Perhaps by the time this reaches you it will be taken care of and over with but, even so, there is no harm in misinterpreting the banner enough to do a little mild grumbling about the undesirable liberties of the press as they affect the doctor.

"We refer especially to the premature, irresponsible, and often incorrect news reports of medical discoveries and 'cures.' Every medical meeting of any size seems to be followed by a plague of them. Someone reports work in progress on the treatment of asthma, for example, and by the time the home town papers pick it up the unsuspecting medical essayist has caused a disruption in economics, transportation, and housing. He has to spend all his time explaining, move out of town, or enjoy a brief but insecure period of big business until the sound and the fury dies.

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"No matter how carefully a medical news article is worded it seems to be pounced on as a sure cure by the public. Then come the phone calls to the doctor to see if it's true what they say in the paper about arthritis, blood pressure, or cancer.

"There was once an advertiser who had a voice boom out at intervals on the radio: 'Many people are using such-and-such for hay-fever.' That was true—many misguided sufferers were trying it at somebody's suggestion—and it was doing them no harm. But the public's amazing ability to interpret the news to suit their own fancy is something from which they should be more carefully guarded. But that is getting away from the freedom of the press and into a more questionable field. All that is intended here is to remark that the fourth estate, like the first profession, is often guilty of taking advantage of a well known public weakness.

"There have also appeared in recent years many things to indicate that the medical profession is not always one hundred per cent perfect.—L. M. D."—An editorial in the October, 1943, issue of *The Journal Lancet.*

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"Additional fuel oil? Have your doctor sign . . . oh, it is gasoline you wish for a motor trip for your health. No matter—just have your doctor sign special form 3784x. Perhaps you are short on your vitamins, or orange juice doesn't agree with you? Well, why don't you get a doctor's certificate and take it to your ration board so that you may get more red points for meat, or blue points for canned pineapple juice? You're tired and would like a rest? Didn't you know that you can get sickness insurance benefits while you are out ill? All you need is a certificate from your doctor. Or perhaps your job doesn't agree with you when you know you can get more money elsewhere. In that case you can get clearance if you show your present work is injurious to your health. Get a certificate from your doctor. What do you mean you can't get a certificate from your doctor? Do you mean to say that he has enlisted in the Army and is with the forces invading Sicily? He can't do that to you. Your health is important, and besides you have got to get a doctor's signature these days to get anything." An editorial from the September, 1943, issue of the *Rhode Island Medical Journal.*

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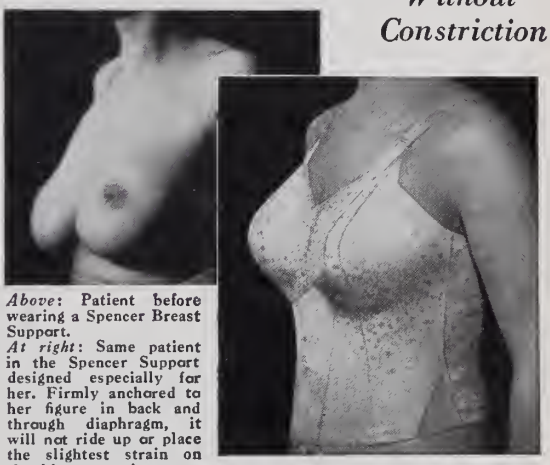

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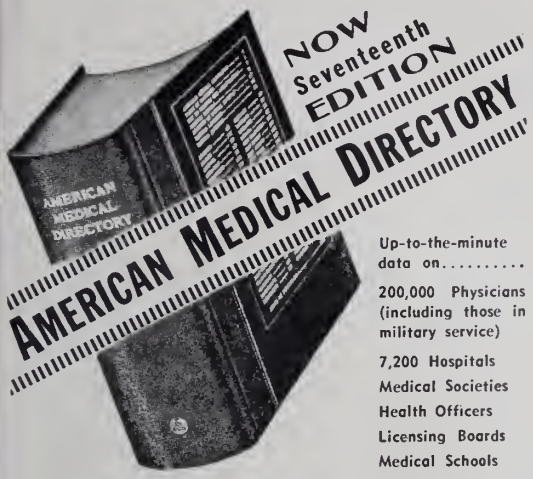

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LEGISLATIVE COMMITTEE HEARINGS ON CHIROPRACTIC BILL 65, A.

AND

ANNUAL REREGISTRATION BILL 305, A.

Stenographic Report of Testimony

Before Assembly Committee on Public Welfare on Woerth Bill 65, A. to Exempt Chiropractors From Present Basic Science Law and Provide Their Own Chiropractic Examiners

STATE OF WISCONSIN

IN ASSEMBLY

No. 65, A.

February 2, 1943—Introduced by Mr. Woerth. Referred to Committee on Public Welfare.

A BILL

To amend 147.23 (1) of the statutes, relating to the regulation of the practice of chiropractic.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

147.23 (1) of the statutes is amended to read:

147.23 (1) No person shall practice chiropractic, or in any manner attempt or hold himself out to do so, unless he shall have a certificate of registration in the basic sciences *issued to him by the state board of examiners in chiropractic upon payment of a fee of $10 to said chiropractic board and after having passed an examination given by said state board of examiners in chiropractic in the basic sciences, anatomy, physiology, pathology and diagnosis, with a grade of at least 75 per cent in each subject,* and a license to practice chiropractic from the state board of examiners in chiropractic, and shall have recorded such certificate and license with the county clerk of any county in which he shall so practice or attempt or hold out to practice, and pay a fee of 50 cents for each recording.

Hearing on Bill 65, A., relating to the Practice of Chiropractic, before the Assembly Committee on Public Welfare, Wednesday, February 17, 1943.

The Committee: Assemblymen Hanson (chairman) Price County; Hammergren, Buffalo and Pepin Counties; MacDowell, Crawford County; Pritchard, Eau Claire County; Squires, Bayfield County; Finch, Langlade County; and Foley, Douglas County, First District. All present.

Chairman Hanson: We will take up bill 65, A. by Mr. Woerth.

Assemblyman Woerth: Mr. Chairman and members of the committee: This bill is self explanatory, and it provides that chiropractors, before they can be licensed, must pass examinations in various subjects of the basic sciences with a rating of at least 75 or better. It also provides that a board of chiropractors shall be appointed by the Governor, with the advice and consent of the Senate, to examine them before they can practice. As it stands today, the board consists chiefly of the medical profession,* and I consider it unfair for doctors to examine chiropractors because chiropractors, in many instances, construe a case just opposite from a doctor of the medical profession. Personally, I have no grievance whatever against the medical profession, and I can truthfully say that I have never had a treatment by a chiropractor. But it has been shown that chiropractors have treated many cases which were considered incurable by the medical profession. There are thousands of such cases. There are two in my district. I feel that chiropractors are every bit as important as the medical profession. I appeal to you in all fairness to give this bill your careful consideration. I thank you.

Chairman Hanson: Are there any other appearances for this bill?

Mr. A. W. Ponath: My name is A. W. Ponath, and I represent the Wisconsin Chiropractors Association. Gentlemen of the committee: I want to correct one impression that might have been left with you on bill 65, A. The bill does not appoint a new board. 65, A. provides that the chiropractic applicant shall be examined in the basic sciences by a chiropractic examining board. I refer you to section 147.23 to verify that. It does not create a new expense. The appointment consists of one member to serve two years, appointed by the Governor with the consent of the Senate. This is recommended by the State Board of Chiropractic Examiners.

In considering this bill, I should like to call your attention to the fundamental principles involved. We are confronted here with prejudice,—the preju-

* *Editor's Note:*—Mr. Woerth was erroneously informed on this point. By law, all members of the Board are lay educators not on the faculty of any school teaching the healing arts.

dice that one arm of science holds for another. Unfortunately, you members of this committee do not have the time nor the facilities to go into all the merits of this thing, but it should not enter into the discussion of this bill anyway.

So far as educational requirements of chiropractors are concerned, these are set up in 147.23. The Basic Science Law neither raises nor lowers standards. And bill 65, A. would neither raise nor lower the standards, but passage of 65, A. will provide that a man going to the Board for examination will have a fair examination. In other words, there will not be the prejudice that is there today.

I don't know how many of you have had this brief here. ("The Evils of the Basic Science Law") In paragraph four there is a list of names. That list is not complete, as there have been some other examiners for 1942 and possibly 1941, who possibly may not have had the title "M. D." However, they are close enough to the medical school at the University of Wisconsin so they see eye to eye with the medical doctors. As a matter of fact, there shouldn't be any friction between these two groups. We have always attempted to aid the public health and feel we should get the chiropractor and medical doctor together on the same case. But we have had to deal with prejudice.

And now, to bring out this prejudice, I want to read something to you. This is from the Inter-County Leader of Frederic, Wisconsin, February 11, 1943, in which a chiropractic doctor by the name of DeJarnette, in Nebraska, writes the Surgeon General of the Army, asking that chiropractors be included in army services. DeJarnette was answered by Larry B. McAfee, Brigadier General, Medical Department, Acting Surgeon General, as follows:

> "Dear Dr. DeJarnette:
>
> "The receipt is acknowledge of your letter of November 23, 1942, with reference to chiropractic treatments for men in the Service.
>
> "The Medical Department is responsible for the health of the Army and is prepared to diagnose and treat human diseases of all kinds. Consequently, there is no necessity for the employment of practitioners of chiropractic to augment the medical service of the Army.
>
> "In addition, chiropractic is not recognized by the medical profession as a satisfactory system of diagnosis and treatment of disease, since in its opinion there is no scientific basis for the system. You will appreciate that there could be no satisfactory cooperation between the military physician who is a member of the medical profession and the practitioners of a system which is quite different in its concepts of professional service."

With that statement as a statement of the attitude and mental approach of the medical profession toward chiropractors, it shows the position which the political-medical group takes. The political-medical group includes those who are now interesting themselves in legislation, and who no doubt take the stand they do in all sincerity. However, I caution you that people who act in all their sincerity can very often be very seriously wrong.

I do not hesitate to call your attention to the fact that today we are faced with a war that is almost exterminating the human race. Now I would like to read just briefly from the May Harper's Magazine.

> (Mr. Ponath read a short excerpt from the May, 1943, issue of Harper's Magazine, to the effect that the present war was caused by the sicknesses of civilization, etc.)

Now, those people who had to do with world events were absolutely sincere. Yet those people made mistakes. And that is the point I want to call to your attention now. Is it more dangerous in the case of those individuals than those who make mistakes which are caused by prejudice? We are confronted with, and will hear from, obviously, the medical profession,—the Medical Society of the State of Wisconsin, because the Medical Society of the State of Wisconsin feels just as does the Surgeon General of the United States when he answered the letter of Dr. DeJarnette.

The medical profession does not study chiropractic. It does not generally recommend that patients go to chiropractors, although there are members of the profession who take chiropractic adjustments, and nurses from the Mayo Clinic, one of the greatest institutions in America, go to chiropractors for their own health. Prejudice and bias are enemies to good judgment.

Recently the newspapers carried the decision of the High Court of the United States telling you of the conviction of the American Medical Association and the District of Columbia Medical Society, in which the American Medical Association was fined $2,500 and the District of Columbia Society was fined $1,500, after upholding the decision of the Department of Justice division handling enforcement of the anti-trust laws. I want to call your attention to just a few pertinent statements on that.

> (Mr. Ponath read from an unidentified document, including the following excerpts: "The illegal activities of organized medicine in this instance are typical of what has occurred in all cities in which" such activities were noted. "Organized medicine should not be allowed to extend control of its methods, payment, services" etc. "There should be fair and free competition between all forms and organizations of medical service, both the new and older types of service," etc.)

Now, my good friends, Mr. Crownhart here will say, "Well, we have furnished cooperative health service. We are not opposed to all such health services." However, the point I want to bring home now is that they are not opposed to these things provided they have set them up.

Now, then, I want to read to the committee from the Congressional Record, 77th Congress, Extension of Remarks Relative to Chiropractic, Physicians in the Army, etc.

> (Mr. Ponath read . . . "Men of science do not know where they are going . . . Our life is influenced in large measure by commercial events . . . Enormous amounts are spent for publicity . . .")

Along that line, you good legislators, I know, appropriate money for the State Medical Society* to make it possible for them to send out these various pamphlets that tell their viewpoint on how properly to take care of disease. But it is only from a medical standpoint,—not from a chiropractic standpoint. We can't get one nickel of that money today to tell the public about our accomplishments. And that is a basis of prejudice.

Now I want to call your attention to the examiners here. Section 147.03 provides that the basic science board shall be three members appointed by the Governor, must be lay educators, and so on. Now these men are Mr. Guyer, of the University of Wisconsin, professor of zoology; a gentleman from Milwaukee who is professor of chemistry, which comes as close to the profession of medicine as you can get. However, they don't conduct the examinations. Under 147.03 we have the examiners. The law says that these fellows shall be selected from a list supplied by the Civil Service Commission. But that does not function in a job that takes less than ten days, so no list was ever certified by the Civil Service Commission, but that would not make any particular difference because of the setup under the laws.

Then the medical men will say either here or on the floor that we have the right of appeal, that if we think we are aggrieved we can go to the courts and secure redress by appeal. Gentlemen, just visualize this situation. Each question bears a certain number of points so that when added up they make 100. That means that around 300 instead of 500 means passing. Suppose I should write an examination paper. They could mark some questions two points, some three points, some three and a quarter points, and none higher than four and a half, and when you get through adding it all up it would be less than 75 per cent, and it would be absolutely impossible by any rule of reasoning to show that he had been shown any prejudice or bias in determining his mark. You just can't prove it. That is why the appeal case is no recourse whatever. The most important thing is fixing the prejudice here. I hope the gentlemen who have to consider this matter will divorce themselves from that prejudice which now exists.

I want to show you this x-ray here, a "before and after" x-ray. It was taken of a patient before he had adjustments by a chiropractor. Then after a series of adjustments, the spine is shown as it appeared afterward. In the first place, a member of the medical profession denies that there is any such thing as subluxation, or the majority of them do. He would deny that the twists in that spine would have anything to do with the physical condition. Here is a patient, a girl 21 years of age. When she came to see the chiropractor in Madison, she had a large neck. She had been everywhere for treatment with no results. The chiropractor maintains this was brought on by conditions which were probably mechanical but through which subluxation was produced in the neck. You ask the medical doctor what to do for the symptoms in that case and then ask the chiropractor and, of course, the diagnosis will be different. I believe that in the examination for diagnosis, if a chiropractic applicant were to discuss it from the chiropractor's standpoint, he would just be marked "zero" according to the medical marking. And that is why one group cannot sit in judgment on the other. If I had the time, I would give you similar situations in the examination involving thousands of cases in which the general approach would be different.

Now this prejudice is the one thing I want to call to your attention here. Democrats and Republicans are equally sincere, and I don't want to cast any aspersions on either, but what chance would a Democrat have taking an examination given before a Republican board? There is a fair comparison, the two political parties. But we place the chiropractors and the medical men in competition with each other. Any patients the chiropractor gets from a medical man, he will not get any pay from. Isn't it human to assume that when we have devolved a world war today that has killed thousands of people who all believe they are sincere, the same mistakes could be made by the members of the political-medical group by controlling others who are trying to earn their bread and butter too? I would be opposed to having chiropractors on any group having such control as medicine has.

There must be fairness. Therefore, 65 A. is perfectly proper as a law to be substituted for the present condition, to provide that the examinations would be given by a separate board appointed by the Governor, the same as the other one. They would give the examination on the basis of passing a man on what he is qualified to practice. Certainly they are not interested in lowering the quality. Do I hear anyone say that the medical people can be trusted more than a chiropractic board? But it is now presumed that the only kind of committee that can protect the public health is a medical committee, and that a chiropractic examining board could not be trusted. Gentlemen, if we have reached that stage of deliberation and thinking in America, then we are so close to Hitler and Mussolini and Hirohito that there is no fun about it. Certainly we must concede sincerity to them in their beliefs, but we are working for a fairness in examining chiropractors in the basic sciences.

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* *Editor's Note:*—Not true.

Assemblyman Hanson: What states have a similar provision at the present time as is offered under this bill?

Mr. Ponath: A similar set-up?

Assemblyman Hanson: Yes, what other states that you know of have such a proposition as is offered under this bill?

Mr. Ponath: I don't know that there are any states today that have it because in every state where we have attempted to change the basic science law, the state medical society has been present to defeat our attempts to change it. In those states attempts have not been successful in bringing about a change because the medical profession is always there to defeat the attempt. However, we have some twenty-two states that license chiropractors. I can get you the exact number that do not have a basic science law. In California recently the basic science law was put to a vote of the people by popular referendum. In other words, there they referred it to the public, and it was overwhelmingly defeated as class legislation.

Assemblyman Pritchard: It would seem from what you say that under the provisions of our statutes now every Governor that we have had, and every Senator, has been prejudiced.

Mr. Ponath: No, I beg your pardon.

Assemblyman Pritchard: Under the present statutes, the Governor shall appoint the members of the basic science board with the approval of the Senate, and it does not say in the statutes that the Governor shall appoint medical men to that board. It says "The Governor shall appoint three laymen." It seems from that that the Governor, and the Senate that confirms that board, is prejudiced. It means we haven't faith and confidence in them. Then there is one more thing I would like to ask: If this bill should pass and become law, then there is no further reason for a basic science board, is there? They would be examining only those licensed to become medical doctors; is that correct?

Mr. Ponath: Medical doctors and osteopaths; they are exempt.

Assemblyman Pritchard: They are the only ones who are exempt?

Mr. Ponath: Yes. Let me ask you a question: Why aren't the other healing arts included in the basic science act? Why aren't the dentists and other doctors in there?

Assemblyman Pritchard: I presume they are not classified the same. Here is a case I will give by a name. A woman lies in the general hospital now where she has been treated for tumor on the brain. Now, isn't it important to any individual that the person who treats the sick should be able to diagnose a tumor on the brain before he starts to treat it? If this person had not been operated upon within ten days, the pressure would have been so great she would have died. What I am getting at is this: Isn't it important that this basic science examination should be uniform because, after all, the human body is the same no matter whether it is black or white? The Good Lord has made us all the same. There can be no disagreement about a tumor on the brain,—it must be just that.

Mr. Ponath: May I answer that?

I am glad we brought up this matter of diagnosis. I have a little girl here. Is she here? I think she may have gone upstairs. Would you go up and see if she is up there? This man's daughter was at Wisconsin General Hospital and was diagnosed as infantile paralysis. After she had been there six weeks, it was found her leg was shortening and was becoming more and more distorted. So they took this little girl out of that hospital and took her to a chiropractor, and she is recovering today to the entire satisfaction of the family and relatives. When you talk about diagnosis, look at these things.

> (At this point Mr. Ponath read an excerpt from a writing by Dr. William Brady whom he described as "the noted physician and author," to the effect that doctors "string their patients along" until the cause of the trouble is clearly developed and until the doctor is willing to "commit himself" as to a diagnosis.)

So what good does it do if you find the patient has a tumor on the brain and then can't take care of the tumor?

> (Mr. Ponath then read from a document, dated Kansas City, October 22, to the effect that many lives were saved at Pearl Harbor simply because physicians could not perform immediate surgery, and, therefore, diagnoses were definite by the time they were able to care for the patients, etc.)

Now, I am not charging or even intimating that any Governor has been prejudiced when he made his appointments to the basic science board. But who did he appoint? He appointed a man recommended by the State Medical Society. He took their advice and he assumed that the man he appointed would be fair. He had complied with the law, essentially, and he was convinced he was doing the right thing. The Senate didn't even bother to look into it because they felt it wouldn't be fair to their job. Would you go back and ask if a person was prejudiced? Isn't it to be assumed that a man is fully protected when he is examined by a chiropractic board of three men recommended by the Chiropractic Association? But this other way we say you can't trust them. I submit that under Bill 65, A. it would be fair and it would protect the public.

Assemblyman Foley: I have a couple of questions. You have indicated that this list of examiners is not complete.

Mr. Ponath: No, it is not.

Assemblyman Foley: How near complete is it?

Mr. Ponath: There may be three or four other names.

Assemblyman Foley: Are these all men who have been examiners?

Mr. Ponath: They have been examiners at different times since 1925.

Assemblyman Foley: Since 1925, how complete is it? What I am trying to find out is, is this a fair sample?

Mr. Ponath: Yes, it is correct up to three or four names.

Assemblyman Foley: And they all have been examiners since 1925?

Mr. Ponath: Yes; this was quite a task because you have to go through the payroll of the University of Wisconsin.

Assemblyman Foley: Since 1925 there have been no more than four other examiners?

Mr. Ponath: Three or four, probably not even that many. If you wish, I will look up the records.

Assemblyman Foley: Now, when chiropractors have passed this basic science test, they are examined by a state board of chiropractors?

Mr. Ponath: True.

Assemblyman Foley: Can you tell me about what proportion of the people taking that examination before the state board pass it?

Mr. Ponath: I can't tell you that.

Assemblyman Foley: Well, your nearest estimate?

Mr. Ponath: I wouldn't even like to try. Only those passing the basic science examination took the chiropractic examination. Whether those who passed the basic science examination passed the chiropractic examination, I don't know. I have a faint recollection that two passed the basic science examination and did not pass the chiropractic board, but I wouldn't want to make the statement.

Chairman Hanson: Are there any other questions?

Mr. Ponath: I would be glad to have any questions because then we can bring out the facts.

Assemblyman Pritchard: In this bill there is no limit to the number on the board,—is it five members?

Mr. Ponath: There is no statement in it.

Assemblyman Pritchard: The bill doesn't even specify three. The bill states "issued to him by the state board of examiners in chiropractic." Then the state board of chiropractors says how many it should consist of and how they are appointed. To all practical purposes, the basic science board would, along with the law, be null and void.

Mr. Ponath: Yes, but that exists today.

Assemblyman Pritchard: And this other board would then give the examination?

Mr. Ponath: Yes.

Assemblyman Pritchard: And the examination for medical doctors? They also would be getting the basic science examination?

Mr. Ponath: We don't choose to dictate to the doctors. Let them run their own affairs. They have a very able man here in Mr. Crownhart, and others. Certainly they can protect the medical men, and we will guarantee that we will protect the chiropractors. Why should we have to resort to subterfuge in order to get fairness on these boards? Why shouldn't the law make it fair? Why should we have to go around and be sure that the Governor is appointing the right man? There must be some prejudice on the part of the Governor in not appointing chiropractors.

If the chairman of the committee will read 147.03, it says, "the Governor, with the advice and consent of the Senate, shall appoint the state board of examiners in the basic sciences. The board shall consist of three lay educators, none of whom shall be on the faculty of any department teaching methods of treating the sick. The term of office shall be six years. A vacancy shall be filled for the unexpired term," etc.

Assemblyman Pritchard: Now this does not say here that the Governor shall appoint anyone who might be favorable to the medical profession, so I can't help but think that all other Governors in the past must have been prejudiced, and the Senate in the same manner.

Mr. Ponath: But that board does not conduct the examination.

Assemblyman Pritchard: In basic sciences?

Mr. Ponath: No, they do not. That board in 147.03 appoints the examiners who conduct the examinations. That is on the list I gave you. It doesn't give the examination.

Assemblyman Pritchard: They supervise it?

Mr. Ponath: Under 147.03 they should appoint a chiropractor to the board. We would be agreeable to that if they appointed chiropractors and let them sit as advisors over the chiropractic examination, but the Medical Society objected to that strenuously.

Assemblyman Pritchard: This board has "all of the say" as to the examination in the basic sciences?

Mr. Ponath: This merely appoints the examiners, and the board appointed under 147.12 gives the examination; 147.03 appoints the group acting under 147.12, but the group under 147.03 does not write the questions nor mark the papers.

Chairman Hanson: Are there any other appearances in favor of the bill?

Mr. Martin B. Franzkowiak (former member of Assembly): Mr. Chairman and members of the committee: This bill is not the first one like it to come before the legislature. We had this same one years ago. I don't see any reason why we shouldn't pass something for the good of the chiropractors. This is just jealousy on the part of the other professions. That is about all I can see. We permit chiropractors to exist in the statutes and put out treatment, they are just like doctors as long as they do that. And this is where the opposition is. They don't ask to be allowed to prescribe prescriptions, or treat diseases in human beings. They don't prescribe anything. You don't have to be afraid of them. They only use their fingers and hands. I don't see what is wrong with that. Judgment has to be used in these things once in a while. You don't mean to tell me that any one of these

people make adjustments in the back by giving medicine in the throat. Some of us in 1933, 1935 and 1937 used to go down regularly every week to see a chiropractor. You can't give yourself everything by taking medicine. I don't see why we shouldn't help them make an honest living.

Assemblyman McDowell: I gather from you that there is something here done that now prevents them from doing that. There is nothing to prevent chiropractors from practicing.

Mr. Franzkowiak: They are asking for certain privileges. Perhaps they have to do something to keep their recognition. This is asking for protection, that is all. I think, myself, they ought to have it.

Assemblyman McDowell: There is nothing to prevent chiropractors from practicing now.

Mr. Franzkowiak: They are not asking special privilege. There is nothing in there wrong.

Chairman Hanson: Are there any other appearances for the bill?

Mr. P. E. Nystrom: My name is P. E. Nystrom, Madison. I have nothing to say except to endorse passage of this bill. I have a son who was sick for a long, long time; he works in the post office. He doctored with practically all the doctors in Madison, and he doctored for his kidneys and his stomach and everything else for years. Then when he was told he could not work at all he went to a chiropractor in Madison. He took I-don't-how-many-treatments, and today he is a well man. And yet these other doctors couldn't help him. I think people should have the privilege of going to chiropractors if they want them, and not be forced not to just because the other doctors don't want them to go.

Assemblyman McDowell: You are all wrong.

Mr. Nystrom: All right, that's my theory.

Assemblyman McDowell: We don't deprive them from practicing at all. You can go to them. We aren't trying to put them out of business. This bill merely covers examining boards.

Chairman Hanson: Are there any other appearances for the bill? If not, we will hear the opposition.

Mr. C. H. Crownhart: Mr. Chairman and Committee Members: I am C. H. Crownhart, secretary of the State Medical Society of Wisconsin. I should like to talk on the merits of this bill, itself, for a moment. In order to talk on the merits of the bill, it is necessary to outline something of the Basic Science Act. Prior to 1915, chiropractors were not licensed nor registered in Wisconsin, but by 1915 they had come into the state in a considerable quantity, and at that time the legislature enacted a law permitting them to practice in this state providing they displayed prominently in their offices a sign stating they were neither licensed nor registered in Wisconsin. Then in 1925, some ten years later, the chiropractic licensure act was established and as a companion measure the chiropractic organization and the State Medical Society supported a Basic Science Act which was passed and became effective, and it has been effective since that time.

The Basic Science Act requires any one in any branch of treating the sick, with certain exceptions, to demonstrate before a board composed of three lay educators their practical knowledge in the four fundamental sciences of physiology (the body in health), anatomy, pathology (the body in disease) and diagnosis. Thus, those who intend to engage in one of the systems of treating the sick must be first examined in the four fundamental sciences in which there can be no difference of opinion. The heart of a chiropractor beats just the same as the heart of a doctor. A finger is a finger, no matter on whose hand it is. A broken finger is a broken finger, again no matter whose hand it is on. These four subjects are covered in an examination for those who wish to treat the sick to assure that they are provided with sufficient basic knowledge so they cannot harm the patients and individuals whose welfare is entrusted to them.

Diagnosis means determination of an ailment, and not the method of treating it. There should not be confusion that in any of these subjects the art of treatment is involved; rather they pertain to virtually exact sciences, knowledge of which should be a fundamental requirement on the part of anyone who intends to treat the sick, regardless of the system he intends to pursue. Being able to recognize a normal, healthy body or its functioning in a normal, healthy way embraces the subject of physiology, while pathology is the subject that relates to the departure of the normal body from a state of complete health. These four subjects, a knowledge of the structure of the body, the knowledge of the body in health, the recognition of disease conditions of the body and, finally, the determination of the character of the ailment are fundamental if the public health is to be protected. I cannot tell you, because I have no way of knowing, how many chiropractors have taken these examinations, or how many physicians or osteopaths have taken them. For our law assures the applicant that he will not need to disclose what form of treating the sick he intends to pursue, and, to assure that, there is also a provision included that the applicant need not even disclose what professional school he may have attended. He simply has to state his age, his address, and the fact that he is a high school graduate. It would be impossible for me or anyone else to tell unless we went through the names of all those who have written the examinations, and it would take a W. J. Burns Detective Agency to see which was which.

Our law has stood on our statutes since the time it was passed, and without change. The personnel of the board has been retained and consists of Professor Bauer, of Milwaukee, recently renominated by Governor Goodland and unanimously confirmed by the Senate; Professor Barber of Ripon; and Professor Guyer of the department of zoology, University of Wisconsin. I have never heard from

anyone, other than perhaps those who were unsuccessful in examination, any condemnation of these three outstanding men who have served the various interests of this state for so many years. The examination procedure is very carefully conducted to assure the utmost fairness, and at the time of examination, Professor Guyer tells me, a set of instructions are submitted to help in framing questions. These instructions are embraced in the orders of the Board as follows:

"1. Examinations should be of a length that can be finished reasonably well in two hours. It is recommended that some choice of questions be permitted, such, for example, as answering five questions out of seven.

"2. The corrected blue books should be returned within a week, as certificates have to be issued promptly to enable the candidates to come before their respective licensing boards. The passing grade is 75.

"3. The purpose of the examination is to determine whether or not the candidate has sufficient knowledge of the body in health and disease to make it safe for him to undertake its treament during illness. The examination should, therefore, not be a highly specialized one.

"4. Examiners should bear in mind that the candidates have been trained in widely different schools. Some are recent graduates, others have been out of school several years. In brief, the examination should be concerned mainly with the matters which the candidate may legitimately be expected to have studied in any good school. Questions should not be worded so that they incline toward any particular type of treatment as against any other type. We want to be thorough, and also fair."

I think the committee also would be interested to know that the individual's only identity at the time of writing the examination is a signed number, at the time he files his application with the board. He is identified on his examination paper only by that number so that those who grade the papers and pass upon them have no knowledge of who the individual is. The paper is graded by the examiner and is assigned back to the number identifying the individual. Professor Guyer tells us that all failures on the part of any applicant come before the board for review, and the law provides that in case an applicant fails in one subject, he may take that examination in that subject over again. If he fails in two or more, he has to take the entire examination over.

I think Professors Guyer, Bauer and Barber are three outstanding gentlemen in Wisconsin whose integrity cannot be challenged before this body, and I am quite sure the State Medical Society and the medical profession are not burdened with defending the characters of these men. I feel very definitely that the argument made before you is based largely upon the so-called underdog theory,—"Give the underdog a chance." But it is a question here of a bill which involves who shall treat the sick, and the question is, "Who is the underdog?" It is not the chiropractor, or any of the other healing arts or cults. The underdog is the sick patient, and he is the one to be protected. I feel convinced that the question before the legislature is not whether this bill will protect and promote the interests of the chiropractors, or destroy the interests of the medical profession, for the interests of the medical profession are thoroughly and completely synonymous with public health, and whatever promotes the welfare of the patient is in the interest of the medical profession. Therefore, the question before you in recommending this bill to the legislature is whether, in the final analysis, it will act in the advancement of the public health of the people of the State of Wisconsin. The State Medical Society, in analyzing this bill, recognizes it for what it is. It fails in every way, shape and manner to protect the public health of the people of the state, and I suggest that in the committee's ultimate determination it be reported out unfavorably. Thank you very much for this opportunity to appear before you. If there are any questions, I shall be happy to do my best to answer them.

Assemblyman Pritchard: What are these professors?

Mr. Crownhart: Professor Bauer was a graduate of Marquette University back about 1905 or 1906, and has a B. S. degree. He is professor of inorganic chemistry at Marquette. He has lived in Milwaukee for many years. Professor Guyer is in the zoology department at the University of Wisconsin and a noted authority in his field. Professor Barber is a physicist at Ripon College. Thank you very much.

Mr. O. T. Toebaas: I am O. T. Toebaas, an attorney of Madison. I am appearing for the Wisconsin Osteopathic Association. We are opposed to this bill. I will not take much of your time. The ground has been well covered. As Mr. Pritchard pointed out, if this bill passes, it would practically leave just the osteopaths and medical men to take this examination in the basic sciences. To that we have no objection, but we do feel that all of those who intend to treat the sick should have all the fundamentals in the sciences of anatomy, pathology, physiology and diagnosis. No man or woman should be permitted to treat the sick or try to heal the injured without knowing these fundamentals. I can say this on behalf of the Wisconsin osteopaths,—they have no difficulty with this board of examiners on these four fundamental subjects in the basic sciences.

Assemblyman Pritchard: How many are there in the state?

Mr. Toebaas: About 150 in the state. Probably about 80 per cent of those are licensed to practice surgery. Before an osteopathic physician can practice, he has to take the same examination in the basic sciences, and after that they are examined by the State Board of Medical Examiners. There is only one osteopathic physician on that board. They take the same subjects as all medical applicants.

Chairman Hanson: Are there any other appearances in opposition to the bill?

Mr. Ponath: In rebuttal, I just want to clarify some statements that were made. In the first place, the Wisconsin Osteopathic Association is one of the few osteopathic associations in the same bed with the medical doctors. They defended them in New Jersey when convicted for the practice of medicine.

Mr. Crownhart said his heart beats the same as mine. That may be true, or it may not be. With me, the theory of chiropractic is what controls that heart beat.

Mr. Brown went to Mayo's and nearly died of heart disease, but he has had no heart trouble since he went to a chiropractor. The theory is what controls the heart beat. It's the thing that controls it. A chiropractor says if you have general normal functions, you will have normal functions of your fingers. Arthritis is arthritis, but if the chiropractor described it in the chiropractic manner in the basic science examination, he would be marked wrong.

It has been said here that there is no way of telling, in writing the examination, whether a man is going to medical school. Certainly, if a man is taking the basic science examination, he may be unaware of the existence of prejudice and say he is attending a medical school, or he can put it on the application blank. I am asking this committee if you can't tell an Irishman is an Irishman when you see him? And so when you take the basic science examination, they can tell.

We always hear about the protection of the sick. Do you know where else you have heard language like that? Do you know who stood up before the whole world and said he was protecting the weak and unfortunate? That is the best propaganda I have ever seen. Just like the one who came to the people of Europe and said, "I will try to protect you." Now, I am not comparing the Medical Society to Hitler but I am saying something has gone wrong there. If they want to come in with a bill to say what they shall do in order to work, all right, but when they say how the chiropractors shall be examined, they are going too far. I should like to file these petitions with you, with the privilege of withdrawing them.

Chairman Hanson: We will take up the next bill if there is no one else to be heard.

Hearing Held on Annual Reregistration Bill 305, A.; Chiropractic Lobby Opposes the Measure

STATE OF WISCONSIN

IN ASSEMBLY

No. 305, A.

March 3, 1943—Introduced by Mr. Hammergren. Referred to Committee on Finance.

A BILL

To repeal 20.44 (2) and 147.13 (3); to amend 20.44 (1); and to create 147.175 of the statutes, relating to the annual registration of physicians and osteopaths, and making an appropriation.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 20.44 (1) of the statutes is amended to read:

20.44 (1) For the execution of its functions, *including the performance of its duties under sections 147.13 (6) and 147.175,* all moneys received by it and paid into the general fund. Of this there is allotted:

(a) To each member of the board such compensation as it shall determine, not exceeding $10 for each day actually spent in attending to the business of the board.

(b) To the secretary of the board a salary, to be fixed by it, not exceeding *$1,800* per annum.

SECTION 2. 20.44 (2) of the statutes is repealed.

SECTION 3. 147.13 (3) of the statutes is repealed.

SECTION 4. 147.175 of the statutes is created to read:

147.175 ANNUAL REGISTRATION OF PHYSICIANS AND OSTEOPATHS. (1) Every person licensed to and engaged in the practice of medicine and surgery, osteopathy, or osteopathy and surgery, in this state, shall, in the month of January of each year, register with the secretary of the Wisconsin state board of medical examiners, upon a form to be furnished by the board. The registration form, to be signed by each registrant, shall contain his name, his residence address, the name of the place and the address at which he is engaged in practice, and any other relevant information which the board may prescribe. Persons licensed or re-licensed in this state to practice medicine and surgery, osteopathy, or osteopathy and surgery, subsequent to January 31 of a given year shall register as required by the terms of this section within 30 days after being so licensed. Any registrant who, subsequent to registering, shall change the address or place of his residence or professional office, or who shall open an additional office, shall, within 30 days thereafter,

notify the board in writing of such change and furnish his new residence or professional address. The secretary of the board, on or before December 1 of each year, shall mail or cause to be mailed to every person registered hereunder the registration form above required. Each person registered hereunder shall display his proper registration certificate conspicuously in his office at all times.

(2) Each registrant shall pay for such registration a fee to be fixed by the Wisconsin state board of medical examiners for each given year, which fee shall not exceed $3 in any year; provided that those who register after January 31 of a given year, shall likewise pay whatever fee has been fixed for that year.

(3) On or before March 10 in each year the secretary of the Wisconsin state board of medical examiners shall certify to the state board of health, which shall cause to be published and mailed to each person registered hereunder, a printed list of those so registered, which list shall be divided according to the branch of healing in which the registrant is licensed. The secretary of the board shall also cause to be mailed a copy of such published list to the secretary of state, the district attorney of each county, each local board of health, the sheriff of each county, the chief of police of each community, and to any other public official who may request or have need thereof.

(4) Every registration made as provided in this section shall be presumptive evidence in all courts and other places that the person named therein is legally registered for the year covered by such registration.

(5) No registration shall be permitted by the secretary of the Wisconsin state board of medical examiners in the case of any person who has been found guilty of any of the unprofessional acts described in section 147.20, and upon conviction for any of said offenses, the registration of any such person shall be deemed automatically annulled upon receipt by the secretary of the board of a certified copy of the information, verdict and judgment, as provided in section 147.20 (3), subject to such registrant's right of appeal. A registrant whose license has been revoked and subsequently restored under the provisions of section 147.20 (4) shall be reregistered by the board upon tendering a certified copy of the order of the trial court restoring his license, together with an application for registration and the registration fee.

(6) The provisions of this section shall not be applicable to any physician while serving in the armed forces of the United States or of an allied government.

(7) If any subsection, paragraph or provision of this section, or its application to any person or circumstance shall be held unconstitutional, such decision shall not affect the constitutionality of any other subsection, paragraph or provision of this section or its application to other persons or circumstances.

Hearing before Joint Committee on Finance, Tuesday, March 9, 1943, relative to bill 305, A., relating to the annual registration of physicians and osteopaths, and making an appropriation.

Present: The entire committee; Senators Lewis, Brown, Hipke, Hilker and Hampel; Assemblymen McIntyre, Grassman, Nelson, Ludvigsen, Benson, Spearbraker, Fritzen, Nicol and Daugs.

Chairman Lewis: We will take up bill 305, A. by Mr. Hammergren.

Assemblyman David I. Hammergren (Buffalo and Pepin Counties): Mr. Chairman and Members of the Finance Committee: This bill is to amend the present law so as to make possible a registration of physicians and osteopaths yearly, instead of just one registration. It provides for not to exceed a $3 registration fee per annum. This money goes into the general fund of the State Treasury to take care of maintaining the work of the State Board. It raises the salary of the secretary from $1,000 to $1,800, and this raise is suggested because his work will be greatly increased in supervising these registrations annually. It would keep him busy. One purpose of the bill is to enable the board to keep a better record of those who are practicing in the state. Sometimes, after they have registered, they go away, they may leave no address, and they don't know whether they have them in this state or not. This will allow the profession to keep an accurate record of them. The bill also takes care of the soldiers, who will not be affected by it while in service. I will not talk on the bill, but I introduced it in behalf of the profession, and there are men here today who will take care of that. I will appreciate it if you consider this bill favorably.

Chairman Lewis: Does anyone else wish to appear for the bill?

Mr. C. H. Crownhart: My name is C. H. Crownhart, and I am representing the State Medical Society of Wisconsin. I am here, Gentlemen of the Committee, at the express instruction of the House of Delegates of the State Medical Society, which last fall endorsed the principles contained in this bill and instructed my office to secure its introduction in this legislature.

Committee to Examine Medical Practice Act

About two years ago, the House of Delegates of the State Medical Society of Wisconsin appreciated that the medical profession was faced with rather serious problems in the period of war emergency which was then developing, and it appointed a committee, by resolution, to examine the Medical Practice Act and to determine in what respect it might be subject to amendment to better administer it and the protections that are supposed to be afforded under it. I think you will be interested in the composition of that committee, which was made up of

Dr. R. G. Arveson, of Frederic, as chairman; Dr. C. D. Neidhold, of Appleton; Dr. C. A. Dawson, of River Falls; and the deans of the two medical schools in Wisconsin, Dr. Eben J. Carey, of Marquette University, and Dr. W. S. Middleton, of the University of Wisconsin, now in service in England or Ireland. This committee was faced with two basic problems. One was concerned with the inventory of physicians and the other was to make certain of the enforcement of the Medical Practice Act. In its judgment, it felt that an annual registration of physicians would help solve the problems created, and it so reported to the House of Delegates last fall which, in turn, instructed me to come before this legislature this session.

Physicians in Service

I wonder how many of you appreciate that while there are approximately 180,000 physicians in the United States, perhaps only 140,000 are in active practice. In the judgment of the Army and Navy, there should be about 6.5 physicians per 1,000 men. They want these physicians from the age group best able to withstand the rigors of active service. That means that the Army and Navy intended to secure upwards of 60,000 physicians from the country as a whole, and there are now in the neighborhood of 45,000 physicians in service. These come from an age group of slightly under 80,000. The physicians are secured on a purely voluntary basis. Not one physician has gone into service by draft. They have all gone in on voluntary enrollment.

Procurement and Assignment Service

In 1941, the President created the Procurement and Assignment Service for Physicians, Dentists and Veterinarians. This required the medical profession in this state and in all forty-eight states to survey the inventory of physician manpower of the country. They proceeded to do so out of their own resources, at their own expense and on their own time. Studies were conducted in an effort to draw the physicians into service from the various communities in such a manner as not to cause a lowering of the community health. Thus, the medical profession felt this problem will be a very distinct one particularly when these men start returning from service, in redistributing them in practice in Wisconsin, and providing the people with an adequate distribution of physician personnel. It is a real problem and one to which the physicians have devoted much time, effort and money to investigate and to develop an inventory for this current year.

It is felt that by an annual registration we can keep track of those who are in active practice in the state, those who have retired, and those who have moved elsewhere. A man who does not register one year can keep his identity by registering another year.

Money For Enforcement to Come From Doctors

The second reason for the introduction of this bill was that it will take out of the pockets of the doctors, themselves, a sum sufficient for the enforcement of the Medical Practice Act. This law was passed in 1897, after ten years' legislative effort by the State Medical Society. It has stood virtually without change since then. It is there not to protect physicians or the osteopaths, but to render basic public health protection to the public. For many years the only regulation had been that if a physician wanted to practice in Wisconsin, he could not collect his fees unless he was a graduate of a reputable school or a member of the Medical Society. In 1897 it was held that he must also be licensed. For many years enforcement was in the hands of the State Board of Medical Examiners; then, some years ago, it was in the hands of the State Board of Health, and it was in 1941, as many of you will recall, that it was transferred back to the Board of Medical Examiners.

Because the enforcement and investigation is largely at a state level, the local enforcement authorities are naturally somewhat apathetic from many angles of investigation and court procedure. The appropriation for the current year has been $4,000, and I think that is close to the highest figure this legislature has ever seen fit to appropriate for an important policing law. Under this bill, the Medical Practice Act can be enforced by the registration fees of physicians, and the money for that purpose would not come from the pocketbook of the state, as it does now.

I think this gives you something of the picture with which we are concerned and the problems we are seeking to solve now, and the ones particularly that we are going to have in the future.

If there are any questions as to the bill, our legal counsel, Mr. Murphy, is here, and he and I will be glad to answer them as best we can. Thank you for this opportunity to appear before you.

Senator Hilker: How many physicians are registered in this state?

Mr. Crownhart: That I cannot give you accurately, but my best estimate is in the neighborhood of 3,000 with about six or seven hundred of these in military service. There are, in effect, about 2,300 now practicing.

Senator Hilker: Another question: Suppose under this law they register one year and fail to register next year but continue to practice? What procedure is there to cover that?

Mr. Crownhart: They would be subject to the general penalty provided under the law, except those in the armed services.

Senator Hilker: I understand that. Those who just register in 1943 might not choose to register in 1944. What would happen?

Registration a Prerequisite to Practice

Mr. Crownhart: It is a prerequisite to practice in Wisconsin.

Senator Lewis: Is this another Integrated Bar Bill?

Mr. Crownhart: No. This has no relation to the bar bill.

Senator Lewis: But they have to pay the fee each year.

Mr. Crownhart: That is true. But the fee is paid the State of Wisconsin and not a private organization.

Assemblyman Benson: This isn't a closed shop?

Mr. Crownhart: No, it is no closed shop.

Assemblyman Benson: But they can't practice without it.

Mr. Crownhart: That is true.

Assemblyman Nelson: You are repealing a section here, 147.13 (3).

Mr. Crownhart: Yes, in the appropriation section and in Chapter 147, there are identical provisions. We are eliminating the duplication.

Chairman Lewis: Are there any more questions of Mr. Crownhart?

Mr. Crownhart: Thank you very much.

Osteopaths Approve Measure

Mr. O. T. Toebaas: Oscar Toebaas, an attorney in Madison, and representing the Wisconsin Osteopathic Association. I think this is a good bill. It is not going to cost the state anything. There are a few things in the bill to take up with the State Medical Society,—a few changes,—but I don't need to bother you with those here.

Chairman Lewis: Are there other appearances for the bill?

Dr. Dawson Speaks in Favor of Bill

Dr. C. A. Dawson: Dr. C. A. Dawson of River Falls. I am a member of the State Board of Medical Examiners. I wish to state that this bill emanated originally from the State Board of Medical Examiners. It is a product of the mental work of Dr. R. G. Arveson, also a member of the State Board. We talked it over many times in Board meetings; this board consists of one osteopath and seven medical men. However, I have yet to hear one derogatory remark about this matter. I think it is a commendable thing, and I hope it is adopted. Thank you.

Chairman Lewis: Are there any other appearances for the bill? If not, are there any appearances against the bill?

Chiropractic Lobby Opposes Measure

Mr. A. W. Ponath: A. W. Ponath, representing the State Chiropractic Association. The particular feature of this bill that I would like to call your attention to is that part which says, "including the performance of its duties under section 147.13 (6)," the third line of the first page one,—147.13 (6). If you will refer to Chapter 147, you will find that this includes not only the physicians and surgeons of the state, but it also includes other professions as well, including the chiropractic profession. I should think we have enough of different kinds of bureaus and subsidiary departments of government in the federal set-up without putting them into the state set-up. Prosecutions for violation of the law, investigations for violations of the law of any type should be under our constituted authorities,—the district attorney of the county and other constituted law enforcement officers.

Here we are setting up control to investigate prosecutions of other than those in the medical and osteopathic professions, and they are paying for that by fees which they can levy against their own members. I am not aware of the $4,000 appropriation, if it has already been made, but whether it is $4,000 or $3,500, it seems to me that it should be a state expense. It should be a state subsidized affair. We do not think the Medical Association can investigate violations any better than district attorneys or the Attorney General could do it.

Is it wise, is it good policy under our form of government to give them special powers such as section 147.13 (6) gives them? I don't think so. I think if they want to use $3 for the welfare of the medical profession and the Medical Society, that is their own business, but I don't think we should have a law which makes it possible to use their fees in a sort of snooping affair of other sciences and, furthermore, somewhat competitive sciences. I don't think it is a healthy condition. If you stop to think, I think you will agree with me that this part of the bill should not be here in this section, if it is there at all. 147.13 is a state affair, it is a part of state prosecution and investigation of violations of statutes. It is not primarily medical, and it is not primarily osteopathic, and here they would use the money which they pay in membership in order to help carry on what we say is a function of government. It should be done by the Attorney General and by the district attorneys. It is that part of the bill that I want to register criticism.

Chairman Lewis: Are there any questions? Are there any further appearances against the bill?

Then the hearing is closed.

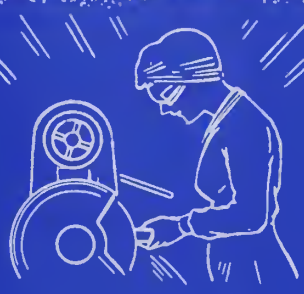
POSTGRADUATE

INDUSTRIAL MEDICAL and SURGICAL

CLINICS

TIME IS PRECIOUS

KEEP 'EM WORKING



MADISON
MAY 5
Hotel Loraine

Under The Auspices of
The Committee on Industrial Health
and
The Council on Scientific Work
of
The State Medical Society of Wisconsin
in Cooperation with
The Industrial Hygiene Unit
State Board of Health

APPLETON
MAY 6
Conway Hotel

KEEP 'EM WORKING

POSTGRADUATE INDUSTRIAL MEDICAL and SURGICAL CLINICS

Madison May 5 — Appleton May 6

"An army marches on its belly." This military truism is attributed to Napoleon. Our own national leaders have within recent months re-emphasized this basic military fact. It is as true today as it was on the day that Napoleon uttered it.

ERWIN SCHMIDT, M. D.

So important is the food supply of the nation and the Army that military leaders have conceded that our "food workers" are on a par in value with the skilled mechanics and factory workers. Neither the Army nor the factories can operate or produce at full capacity and efficiency unless they are supplied with this vital commodity.

Wisconsin physicians have, among other wartime obligations, the self-imposed responsibility of keeping to a minimum the time lost by employes as a result of illness or accident. This applies with equal importance to farmers and factory employes. We must "keep 'em working." It is of the utmost importance to keep our farm and factory home-front producers in constant high-gear production.

Home-front physicians will be better able to make this additional contribution to the wartime effort and to the maintenance of uninterrupted work schedules if they will avail themselves of the advantages to be obtained by attending the special scientific program which will be presented by the Council on Scientific Work, the Committee on Industrial Health, and the Industrial Hygiene Unit of the State Board of Health in Madison on May 5 and the identical program in Appleton on May 6.

Lay Program

In addition to the full-day scientific program for physicians, a special *Industrial Health Conference* will be held for employers, personnel directors, industrial nurses and others interested in health problems of employes. Three round-table luncheons of especial interest to this group will be held each noon. The luncheons will be followed by an afternoon program at which eight special discussions will be held on topics of current and vital interest to employers. Outstanding authorities have been secured to advise and counsel with them on their health problems.

The program has been arranged by Erwin Schmidt, Chairman of the Council on Scientific Work, with the assistance of the Committee on Industrial Health and Paul A. Brehm, Director of the Industrial Hygiene Unit of the State Board of Health.

Each member of the Society is urged to call this meeting to the attention of his employer friends and to urge them to attend, and, whenever possible, to bring an employer with him to the meeting.

The evening sessions of the "Keep 'Em Working" Medical and Surgical Clinics have been set aside for a joint conference in which both physicians and employers will participate. The Council on Scientific Work feels that it is indeed fortunate in obtaining the three speakers which have been secured for the evening sessions.

BRING AN EMPLOYER

Evening Dinner Conference

PAUL A. BREHM, M. D.

P. A. BREHM, M. D.

Dr. Brehm, Director of the Industrial Hygiene Unit of the State Board of Health, is intimately acquainted with the health problems of industry and the accomplishments that can be attained through the joint efforts of physicians and employers. The Council on Scientific Work has asked Dr. Brehm to present to physicians and employers the industrial health problems of Wisconsin and to point out what can be done to improve the state's already enviable industrial health record. The topic selected by the Council on Scientific Work for Dr. Brehm's part in the Dinner Conference is "The Safeguarding of Industrial Health by Industry and Medicine."

MR. W. D. JAMES

MR. W. D. JAMES

So enthusiastically received were the remarks made by Mr. W. D. James at the Industrial Medical and Surgical Clinic held in Milwaukee on November 17 that the Council on Scientific Work urged Mr. James to take part in the meetings to be held in Madison and Appleton. The dynamic personality and the forceful delivery of Mr. James will add both zest and interest to the conference. As president of the James Manufacturing Company at Ft. Atkinson and president of the Wisconsin Manufacturers Association, Mr. James has had an unusual opportunity to study not only health problems which confront him as a manufacturer, but the problems of manufacturers generally in Wisconsin. The title of Mr. James' discussion is "As Industry Sees the Problem."

From The Crane Company in Chicago the Council on Scientific Work will bring Dr. J. H. Chivers, the Medical Director of this nationally known company to discuss at the evening dinner conference the subject "Why Employees Stay at Home and What Can Be Done About It."

Absenteeism in industry has impaired our war effort to such an extent that legislation, discharge, and other punitive measures have been taken to curb it. The absence from work of an employee means more than just the loss of his production. It means an upset in the production schedule and the organization of the intricacies of large-scale production. Absence from the field by the farmer may delay crops, impair production of the farm and, if marked, diminish our food supply.

There are many causes of absenteeism other than sickness and injury which should have borne the brunt of the publicity which has been given to the absence from work in our industries and offices throughout the country. Some of the other factors which enter into the absenteeism problem are holidays, hunting seasons, ball games, and the seven-day week.

There are some causes of absenteeism which are affected by the employee's health that can be corrected and eliminated by a joint study of the problem by the employers and physicians. It is only through focusing the attention of Wisconsin physicians and employers on the problems which are confronting the employers that they can assist them in the solution of their problems. From the firing line where these problems are met every day comes Dr. Chivers, who will discuss problems and offer suggestions.

Also to be discussed will be the responsibility of returning sick and injured employees to their jobs as soon as sound medical judgment will permit. The purpose of the clinics, the industrial health conference and the evening dinner conference is to bring the problems of industry and medicine together in order that a joint solution may be evolved.

BRING AN EMPLOYER

A. A. SCHAEFER, M. D.

R. C. WARNER, M. D.

MAJOR B. B. LARSEN

MAJOR C. S. HIGLEY

Scientific Program

MORNING

8:30– 9:00 Registration

8:30– 9:00 Motion Pictures (Colored—Silent)
Sciatic Pain Caused by Ruptured Intervertebral Disc
Produced by Dean H. Echols, New Orleans, Louisiana

9:00– 9:10 Introduction of Program
Madison—H. L. Greene, Madison, Committee on Industrial Health
Appleton—T. J. Howard, Milwaukee, Committee on Industrial Health

9:10– 9:30 Late Developments in the Treatment of Burns
A. A. Schaefer, Assistant Clinical Professor of Surgery, Marquette University School of Medicine, Milwaukee

9:30– 9:50 Keratoconjunctivitis
Raymond Warner, Milwaukee

9:50–10:10 Clinical Concept of Shock and Its Treatment
Major Bernard B. Larsen, Chief of Surgical Service, Station Hospital, Truax Field, Madison. (Civilian Instructor in Surgery, Western Reserve University, Cleveland, Ohio)

10:10–10:30 Virus Pneumonia in the Army and Its Relation to Industry
Major Charles S. Higley, Chief of Medical Service, Station Hospital, Truax Field, Madison. (Civilian Instructor in Internal Medicine, Western Reserve University, Cleveland, Ohio)

10:30–10:45 RECESS

10:45–11:05 Pros and Cons for the Routine Immunization of the Industrial Worker Against Tetanus
C. N. Neupert, State Health Officer, Madison

11:05–11:25 Why Do Fractures Head the List of the Causes of Disabilities?
Chester C. Schneider, Milwaukee

11:25–11:45 How Can Fracture Disabilities Be Reduced?
William R. Cubbins, Professor of Bone and Joint Surgery, Loyola University School of Medicine, Chicago

C. N. NEUPERT, M. D.

C. C. SCHNEIDER, M. D.

J. A. E. EYSTER, M. D.

A. R. CURRERI, M. D.

BRING AN EMPLOYER

Noon Round-Table Luncheons

12:00– 1:45 NOON ROUND-TABLE LUNCHEONS

1. Dermatosis in Industry
   G. A. Cooper, Research Assistant in Dermatology, University of Wisconsin Medical School, Madison

2. Treatment of Burns
   A. A. Schaefer, Milwaukee

3. Respiratory Infections
   Madison—E. L. Belknap, Assistant Clinical Professor of Medicine, Marquette University School of Medicine, Milwaukee
   Appleton—Major Charles S. Higley, Truax Field, Madison

4. Common Industrial Fractures
   Madison—H. L. Greene, Madison
   Appleton—Chester C. Schneider, Milwaukee

5. War Gases
   J. A. E. Eyster, Professor of Physiology, University of Wisconsin Medical School, Madison
   A. R. Curreri, Assistant Professor of Surgery, University of Wisconsin Medical School, Madison

6. Industrial Hand Infections and Accidents
   Madison—A. R. Tormey, Madison
   Appleton—William R. Cubbins, Chicago

12:00– 1:45 ROUND-TABLE LUNCHEONS FOR LAY INDUSTRIAL HEALTH CONFERENCE

7. The Placement Examination
   C. O. Sappington, Chicago

8. Optimum Hours of Work

9. How Health Engineering Can Help Industry
   Mr. O. T. Nelson, Building Commissioner, Industrial Commission, Madison

Afternoon Scientific Sessions

2:00– 2:20 Gas Used in Warfare
J. A. E. Eyster, Madison

2:20– 2:40 Diagnosis and Treatment of Gas Casualties
A. R. Curreri, Madison

2:40– 3:00 New Medical Problems War Industry Has Brought to Wisconsin
P. A. Brehm, Director of Industrial Hygiene Unit, State Board of Health, Madison

3:00– 3:20 Common Colds and War Efficiency
W. E. Grove, Clinical Professor of Otolaryngology, Marquette University School of Medicine, Milwaukee

3:20– 3:35 RECESS

3:35– 3:55 Health Problems Provoked by Employment of Women in Industry
Stewart Scrimshaw, Ph. D., Professor of Sociology, Marquette University, Milwaukee

3:55– 4:15 Placement Examinations in Industry
C. O. Sappington, Chicago

4:15– 4:35 The Problem of Employing the Physically Handicapped and Aged
Orlen J. Johnson, Council on Industrial Health, American Medical Association, Chicago

4:35– 4:55 Accidents Peculiar to Agricultural Industry
J. H. Karsten, Horicon

4:55– 5:30 Scientific Motion Picture

C. O. SAPPINGTON, M. D.

W. E. GROVE, M. D.

S. SCRIMSHAW, Ph. D.

BRING AN EMPLOYER

W. W. BAUER, M. D.

MR. G. F. KULL

NORBERT ENZER, M. D.

Afternoon Lay Industrial Health Conference

Following the initial clinic held in Milwaukee, numerous requests were made to make available to employers, industrial nurses, personnel directors and others accurate and authoritative information looking toward the solution of many of the health problems found in industrial plants. To meet this demand the Society has arranged for three noon round-table luncheons designed to be of especial interest to this group, and has planned a full afternoon program which will be conducted simultaneously with the scientific program.

LAY PROGRAM

2:00– 2:20 The Nurse in Industry
Milton Kronnenberg, Assistant Professor of Bacteriology and Public Health, University of Illinois College of Medicine, Chicago

2:20– 2:40 Health Education of Employes: Facilities and Procedures
W. W. Bauer, Director, Bureau of Health Education, American Medical Association, Chicago

2:40– 3:00 Absenteeism—How the Wisconsin Manufacturers Association Can Cooperate in the Solution of the Problem
Mr. George F. Kull, Secretary, Wisconsin Manufacturers Association

3:00– 3:20 Value of Midmorning and Midafternoon Lunches
Elmer L. Sevringhaus, Professor of Medicine, University of Wisconsin Medical School, Madison

3:20– 3:35 RECESS

3:35– 3:55 Optimum Hours of Work—Fatigue in Relation to Production
Norbert Enzer, Milwaukee

3:55– 4:15 Wisconsin Workmen's Compensation Act
Mr. Harry A. Nelson, Director, Workmen's Compensation Division, Industrial Commission, Madison

4:15– 4:35 Employe Viewpoint
Mr. Harvey Kitzman, Racine

4:35– 4:55 Actual Demonstration of Placement Physical Examination
C. O. Sappington, Chicago

M. H. KRONENBERG, M. D.

MR. H. A. NELSON

E. L. SEVRINGHAUS, M. D

BRING AN EMPLOYER

Scientific Exhibits

Through the generous cooperation of Dr. Thomas G. Hull, Director of the Exhibit Division of the American Medical Association, we will be able to present both in Madison and in Appleton a series of scientific exhibits on Industrial Health. Scientific exhibits will be shown which will be of interest to physicians. Other exhibits will be presented that will have direct appeal to our lay guests.

Amputations

American Medical Association

This is an exhibit from the Council on Physical Therapy of the American Medical Association, consisting of manikins showing the most suitable sites for leg amputations, together with charts and posters showing the most suitable sites for finger amputations. A pamphlet containing information about the exhibit will be distributed. Amputations were responsible for the loss of 219,474 working days to Wisconsin workers and industry in 1941. The cost of indemnity and medical fees totaled $501,444.

Tuberculosilicosis

American Medical Association

This is an exhibit prepared for the Council on Industrial Health of the American Medical Association by the Saranac Laboratory, consisting of transparencies and posters dealing with the symptoms, signs and clinical course of silicosis with tuberculosis and tuberculosilicosis.

Pneumoconiosis

American Medical Association

This is an exhibit prepared for the Council on Industrial Health by the Saranac Laboratory consisting of transparencies and posters dealing with the causes, symptoms, physical signs and diagnosis of benign non-specific pneumoconiosis.

Asbestosis

American Medical Association

This is an exhibit prepared for the Council on Industrial Health of the American Medical Association by the Saranac Laboratory, dealing with the symptoms, physical signs, clinical course, diagnosis and prevention of asbestosis.

Industrial Dermatitis

American Medical Association

As a result of industrial dermatoses, 8,000 working days were lost to Wisconsin workers and industry in 1941 at a cost of over $34,000. The exhibit contains a description of some of the causes of industrial dermatoses, the clinical types, diagnosis, treatment and prevention of dermatoid conditions encountered in industrial plants, offices and factories. Included in the exhibit are approximately fifty photographs and several small charts.

This exhibit consists of a large series of photographs of dermatological conditions which have been collected by the Section on Dermatology and Syphilology of the American Medical Association. The subjects covered relate to those conditions which occur frequently in industrial plants.

Silicosis

American Medical Association

This is an exhibit prepared for the Council on Industrial Health of the American Medical Association by the Saranac Laboratory, consisting of transparencies and posters dealing with the causes of silicosis, the principal sources of silica hazards, the essential factors in the production of silicosis, atmospheric concentration of dust, and individual susceptibility. This disease resulted in 48,000 days of disability to Wisconsin workers in 1941.

Industrial Hygiene Unit of the State Board of Health

Paul Brehm, Director

This is a display of equipment used by the Industrial Hygiene Unit in taking samples of fumes, dusts, vapors and gases in Wisconsin factories.

Charts showing the absenteeism in Wisconsin will also be shown. Wisconsin's absenteeism, which can be still further reduced, is lower than any other state in the country. In 1939 the average employe lost two and one-half days of work due to illness or accident. The following year this dropped to two and one-quarter days, and in 1941, in spite of adverse factors such as the employment of inexperienced workers, older workers, a greater ratio of women workers, and accelerated production, the rate remained at the enviable low record of two and one-half days.

Safety Division

Wisconsin Industrial Commission

The exhibit of the Safety Division of the Wisconsin Industrial Commission will consist of personal safety devices designed for the exclusive protection of the wearer. Among the items to be exhibited will be four distinct types of respirators, one type being that commonly used to protect the wearer from dust, a second will be that used in paint spray booths, and others will include the all-purpose gas mask, the supplied air respirator and the hose mask.

In addition there will be shown sample miniature clothing to protect the wearer, and the commonly used types of goggles.

Continuously throughout the two days' meeting there will be shown sound film strips on industrial health topics.

Treatment of Burns

A. A. Schaefer, Milwaukee

As a result of burns, 53,000 working days were lost by Wisconsin workers in 1941 at a cost of $173,384 for indemnity and medical fees combined. Several types of treatment will be shown in this exhibit. Pictures will show cases of severe burns, the treatment employed and the results. Plastic procedures employed to correct contractures will also be demonstrated.

BRING AN EMPLOYER

Our Industrial Hygiene Unit

Under the directorship of Dr. Paul A. Brehm, the Industrial Hygiene Unit of the State Board of Health serves as an advisory agency which was established to study health problems in Wisconsin's industry and to advise and counsel all those having industrial health problems who desired the unit's help.

Industrial Hygiene activities are purely fact-finding in nature. Studies and investigations are made in all types of industrial establishments to determine any working conditions which may influence the health or safety of the workers. When such conditions are found, recommendations for control of the hazards and improvement of the general working environment are made to management.

The environmental working conditions which may affect the health and safety of the workers are many and varied. Specific determinations are made of exposure to the hundreds of toxic dusts, fumes, vapors and gases. In addition, the health and productive capacity of the workers are influenced by such working conditions as improper sanitary facilities, poor housekeeping, lighting, ventilation, noise, fatigue and inadequate first-aid facilities.

The most important function of Industrial Hygiene is to advocate measures which will improve the general health of the workers and prevent unnecessary time loss due to ordinary illnesses. These measures include pre-employment and periodic physical examinations, proper nutrition, venereal disease control, dental hygiene, tuberculosis case-finding programs, immunization programs, adequate nursing services, health educational programs, water and milk supply in the plants, and special problems as related to women in industry.

The recent years have witnessed a tremendous growth anud increased production of industry occasioned by our defense and war efforts. In view of this national crisis it became imperative that the workers stay on the job and produce the necessary war goods and every industrial hygiene effort was to be directed toward prevention of any type of disability which would hinder this accomplishment.

Specific activities were as follows:

1. Planned studies for the evaluation of health hazards from exposure to toxic dusts, fumes, vapors and gases.

A. Twenty-four milk canning plants were studied under winter and summer conditions for exposure to lead fumes and dust.

B. Sixteen brass foundries studied under winter and summer conditions for exposures of lead, zinc and manganese fumes and dust.

C. Fifteen paper mills surveyed for occupational exposures in connection with absentee studies.

2. Miscellaneous investigations in all types of industries and for many different hazards. These studies were conducted at the request of labor, industry, industrial commission, insurance carriers, physicians, nurses, health officers and local residents. Total planned and miscellaneous studies were as follows:

	1940	*1941*
Number of plants studied	218	256
Number of laboratory determinations	1,343	1,814

3. Industrial hygiene nurse studied nursing facilities and problems in 90 large factories employing 122,000 men and women.

4. Sponsored a symposium on Industrial Public Health Nursing services. Held in Milwaukee, February 20–22, 1941. Total registration, 508. Out of state attendance represented 12 states and the District of Columbia.

5. Absentee studies in 15 paper mills employing 7,500 men and women. Health educational programs have been organized on the basis of the health problems found.

6. Cooperation with such groups and agencies as the State Medical Society; the Industrial Commission, Labor Unions, Manufacturers' Association and industrial organizations, Nursing Associations, Wisconsin Council of Safety, National Safety Council, U. S. Public Health Service and local health agencies.

7. Educational activities included lectures to medical students and student nursing classes; talks before industrial safety organizations, industrial and labor groups, public health nursing classes, medical society meetings and public health nursing conferences. Papers were presented before national medical, safety and industrial hygiene conferences.

8. Research: Devising new methods of chemical analysis and construction of field sampling equipment. All laboratory analyses and research studies are made at the State Laboratory of Hygiene.

BRING AN EMPLOYER

LEGISLATIVE COMMITTEE HEARINGS ON COMPULSORY HEALTH INSURANCE BILL 327, A. AND ON BILL 333, A. TO LEGALIZE AND PROMOTE UNSUPERVISED FORMS OF MEDICAL AND HOSPITAL INSURANCE SCHEMES

Stenographic Report of Testimony Before Assembly Committee on Public Welfare on Compulsory and Voluntary Sickness Insurance Bills

327, A. by Mr. Westfahl, relating to establishment and administration of a system of health insurance, providing penalties and making an appropriation.

333, A. by Mr. Westfahl, relating to formation of cooperative and other associations, providing medical and hospital care, prevention of discrimination against, exemption from insurance laws, and providing a penalty.

Hearing on Bills 327, A., and 333, A., before the Assembly Committee on Public Welfare, Wednesday, April 14, 1943, 2:00 p. m.

The Committee: Assemblymen Hanson (chairman) Price County; Hammergren, Buffalo and Pepin Counties; Pritchard, Eau Claire County; Finch, Langlade County; and Foley, Douglas County, First District, present; Assemblymen McDowell, Crawford County; and Squires, Bayfield County, absent.

Chairman Hanson: We will next take up bill 327, A. by Mr. Westfahl, relating to establishment and administration of a system of health insurance.

Mr. J. F. Friedrick, (Milwaukee): I represent the Federated Trades Council of Milwaukee, which is the central body of the Federation of Labor in that county. I also have been asked to register on this bill for William Nagorsne, legislative representative of the Wisconsin Federation of Labor.

This bill, 327, A., is a measure which the Wisconsin State Federation of Labor has advocated for quite a period of years. It is designed to set up a system of health insurance for workers in industry. Before going into the details of the bill, Chairman and Gentlemen of the Committee, I would like to say a few words on the general need for this kind of legislation.

Four Main Hazards For a Worker

Generally, there are four main hazards for a worker: Those are the hazards of injury, the hazard of unemployment, the hazard of old age, and the hazard of sickness,—all of which prevent him from earning a living for himself and his family. It has been the policy of organizations of labor to seek to prepare some safeguards against those hazards and at least to alleviate the suffering which comes when the worker meets one of these hazards.

We now have the Workmen's Compensation Act, which alleviates the risk of accident and injury. We have unemployment compensation which alleviates, by cash benefit, the risk that comes through unemployment. We have in the Social Security Act nationally, a system of old-age insurance which to some extent protects the worker and alleviates his needs when he reaches old age.

The only one which we have not recognized as yet is the one of providing some means for the worker and his family to take care of himself during a period of illness, and we feel it is time that this question is recognized. As a matter of fact, there are more and more indications that it is being recognized, and in the discussions of the extension of social security on a national scale there is quite a bit of comment about the necessity of providing some measure of health insurance. We, here in the State of Wisconsin,—the organized labor movement, —have felt that legislation of this kind would be more beneficial and would be more easily administered and handled if it were on a state level rather than on a national level. It is for that reason that the Wisconsin State Federation of Labor is one of the organizations of labor which has supported the state system of unemployment compensation as against complete federalization. I point this out to you in this connection because the trend for health insurance is gaining ground. If the states do not act upon these measures, it will be but a question of time, and perhaps a relatively short time, until we will have some sort of national system. As a matter of fact, I understand Wisconsin and its legislature have passed a bill to study this question of federalization and the encroachments of the federal government upon state legislation. This might be one of the things which the legislature might well consider in connection with this proposition.

Now, the reason why we feel a system of health insurance should be provided for workers is because workers in most instances are not in a position to meet the great hardship which comes with any serious illness. It is impossible for the wage earner to foresee because it is unpredictable as to what his medical expense and his hospital expense is going to be. And even if he is of a thrifty nature, one serious illness may wipe out his savings and place him in debt after almost a lifetime of hard work.

We feel, however, that there is a possibility of the worker getting adequate medical and hospital care through a system such as proposed here, which

would spread the cost among all workers on the basis of insurance. We know that today workers, if faced with a serious illness requiring hospitalization or the attentions of a physician, do not secure and have the medical service which they ought to have in order to keep themselves in good physical condition so they can perform their work. I think that is a serious matter, particularly at this time when it is so necessary to preserve the manpower of this nation in order that the industries of this nation may operate at their fullest efficiency in our war effort.

The Question of Absenteeism

I was interested in a study which was made recently in the city of Milwaukee by a committee of the Medical Society of Milwaukee County on the question of absenteeism, about which we have heard so much. They found that absenteeism in Milwaukee industries ran to about 4 per cent, and of that 4 per cent, 3 per cent was due to sickness and accidents. That is, it is due to a condition beyond the worker's control. We feel that in many instances workers, if they have ready access to medical service, if they are able to get out and get the services of a doctor without it immediately costing them an outlay of money which they feel they cannot afford, many of the illnesses which cause absenteeism over a period of time might be prevented.

We have been interested in this matter for some time, and we followed out some studies made on this question of the health of workers. I should like to quote to you here some of the findings that have been made. For example, the National Health Conference held in Washington in 1938 had the following to say about it: "It is estimated that approximately 20,000,000 cases of disabling illness will occur in this population," (that is, that class which has an income of around $800 or $1,000 a year) "during a year, of which minimum of 8,000,000 cases will cause disability of at least a week's duration. Under the conditions prevailing in 1935, about 2,000,000 of the more seriously disabling illnesses will receive no medical care; and the 6,000,000 medically attended cases of this category will include over 2,000,000 patients in general hospitals."

It is because of the economic status of those that the incidence is the largest burden. "It is significant to note that the death rate is considerably higher for the poor than for the well-to-do. This is evident from general death rates examined by occupation, from infant mortality rates, from tuberculosis rates, and from mortality statistics for other important causes of death."

It is also emphasized by one of the committees of that Conference that "a study made in the last prosperous years before the depression set in showed that well-to-do sick persons received nearly three times as many services from physicians, six times as many in each 100 received dental care, two and one-half times as many had health examinations as did self-sustaining families with incomes under $1,200 a year."

This simply means that people with low incomes who are, under present conditions, on a fee-for-service basis have to have an immediate outlay and they feel they cannot afford to have this medical service, at least proper and adequate medical service. I have here and will furnish the members of the committee material gathered on that which I will not take time to go into at the present time, but I think you will find some of this material interesting on this question of the need for health insurance.

Provisions of Bill 327, A.

Now, this bill, which provides for health insurance, provides for a tax of 2 per cent on the earnings of the employes who are covered and it provides for a similar amount to be paid by the employers. This would really provide that 4 per cent of the earnings for the employe be paid into the fund, out of which medical and hospital services would be provided under this plan. It sets up a department in the state government which is to be responsible for the administration of this act, formulation of policies, and seeing that the provisions are carried out. It would operate through a director, who would have in association with him a medical officer who would have to be a physician or doctor, and another feature provides that he would have to be recommended by the State Medical Society. In each locality, panels would be set up for furnishing service to those who are under the provisions of this act. Any physician and every physician who wants to become a member of the panel and who is elected to the panel could then be called upon by those who are in need of the services.

There are provisions for the removal of members of the panel where it is apparent there is some reason for removal.

We feel that by the institution of this sort of system, many of the workers in this state who today are not getting proper medical attention and who, because of that, are apt to develop serious illnesses which in turn means a great deal of loss of time and which in many cases means that they and their families may become a burden upon the community, could have the advantage of much preventive work which could be done in this manner, and that is the one thing the state ought to look into so far as providing standard care for workers is concerned.

The declaration of policy of the bill itself I think gives you the gist of what we are driving at in this sort of legislation. I trust this committee will give this legislation your favorable consideration.

Assemblyman Foley: As I understand it, this bill provides that any employe must come under this act whether he wants to take advantage of it or not?

Mr. Friedrick: Yes; that is why it is on a compulsory basis.

Assemblyman Foley: I also understand that the employe, if so inclined, can call a chiropractor for treatment; he would be able to take chiropractic treatment out of the funds established?

Mr. Friedrick: They are not included in it.

Chairman Hanson: This department would be set up in the Board of Health?

Mr. Friedrick: That is right.

Assemblyman Foley: But under the supervision of the insurance department?

Mr. Friedrick: No, it is not. I do not believe it is under the supervision of the insurance department.

Chairman Hanson: Are there any other appearances?

The Cost

Assemblyman Hammergren: In the mechanics of this bill, have you given any thought to the cost of these provisions?

Mr. Friedrick: Well, we feel the cost would be paid out of the contributions of the employer and employe.

Assemblyman Hammergren: Out of the contributions? You have no idea what the cost would be, or what would be left. Would the fund be sufficient to care for all that?

Mr. Friedrick: The amounts arrived at, of course, have been subject to some study in this matter on health insurance measures in Great Britain.

Assemblyman Hammergren: There is no limit to the benefits to be paid?

Mr. Friedrick: Yes, there are certain limits or benefits to be paid to a person. Yes, there is a limit.

Assemblyman Hammergren: Tuberculosis is excluded?

Mr. Friedrick: That is right.

Assemblyman Hammergren: For example, certain treatment would be excluded? Industrial accident would be excluded?

Mr. Friedrick: Yes.

Chairman Hanson: Any other appearances in favor of bill 327, A.?

The Wisconsin Welfare Council

Elizabeth Brandies (Mrs. Paul Raushenbush, Madison): I represent the Wisconsin Welfare Council, which wishes to be registered in favor of this bill. I won't attempt any detailed analysis, but I want to supplement a statement made by Mr. Friedrick, a point which he made which, personally, I feel very strongly about. That relates to provision to take care of the hazard against which the wage earners have no protection in the United States. But some provision is coming, and I feel very strongly because it is up to the states to take action if they are to preserve state government and to have the state functioning in these important fields rather than have such things operated from Washington. I think that even the State Medical Society, which has been afraid of government action in this field, will agree that they would rather have action on the state level than have action on the national level, so that the program will be one for Wisconsin and not one for the nation.

This bill, as drafted, is not the same type of thing that is talked about as a national program. There are different ways of going about this. Maybe this is not the best way, but it is a way to try to meet this problem of meeting the heavy cost of medical care which the wage earner,—even the pretty well paid one,—cannot budget against. As many of you know, if you have a serious illness in the family you run into a tremendous expenditure of money. You can't figure it in advance. It is a peculiar kind of thing. It should be handled on an insurance basis, pooling the risk in large groups over a period of time. A man may go along for years without illness and then suddenly run into a long, serious illness.

This bill provides 4 per cent for each person, 2 per cent from the worker and 2 per cent from the employer, on a payroll basis. It is estimated that it will provide an amount for covering the cost of medical care. It does not provide cash benefits for the worker while incapacitated from illness. It provides merely the cost of medical care for himself and his dependents. The set-up in regard to the relationship with doctors, the way in which they should be paid, is not stabilized in the bill and it is left up to being worked out directly with the advisory committee and by agreement between the various groups who would be providing the service. I feel this would be a very constructive measure. If we can work out something along these lines in Wisconsin, I would like to see the state do it instead of seeing the national program passed.

Assemblyman Foley: What is the idea of making this compulsory?

". . . To Protect the People Against Themselves."

Miss Brandeis: There is the possibility of having these things voluntary, but experience has shown in a good many fields that if you want to give adequate protection, you have to protect the people to some extent against themselves. That was true of workmen's compensation. Previously there was an elective law insofar as industrial accidents were concerned for the employer and the employe, but eventually, after a good many years, all employers agreed they wanted a compulsory law with certain exceptions. However, they are not opposed, so far as organized workers are concerned, to making contributions on the theory that it is not solely the employer's problem. The worker does become sick without any relation to his working condition. This is not a part of industrial accident with unemplyment compensation. The worker should help "foot

the bill," and this, after all, provides for his care, with the aid of his employer, against the contingency which may or may not put him heavily into debt. As Mr. Friedrick pointed out, many workers do not get adequate medical care for themselves or for their families because of the fear that they won't be able to meet the doctor's bill. Doctors always tell you, and I think it is true in most cases, that if they ask for care they will get that care free if they can't pay for it, but a person who tries to pay his own way will let the illness go on rather than call in a doctor, and he hopes that illness will disappear in time without expensive medical care. Therefore, many people don't ask for medical care or they do put off having an operation. The doctor tells them they should have the operation, but they don't do it. There is an exceedingly heavy incidence of sickness expense, and, therefore, it is particularly appropriate to have an insurance program to cover sickness. The United States is the only country in the world that has a high degree of industrial work which does not provide health insurance.

Assemblyman Foley: Compulsory insurance?

Miss Brandeis: I think it is correct to say that it is compulsory in most countries. Of course, Germany and England have extensive systems and have had for twenty or thirty years, or longer. We came rather close to getting it shortly after workmen's compensation came in, in 1919, and a start was made. An interim committee was set up by the legislature to study it, and it studied the possibilities of a health insurance program. The committee recommended in favor of it but it didn't reach the legislature. I think this theory is drawing to a close, and the demand for legislation is insistent and it is going to come about.

Chairman Hanson: Are there any other appearances in favor of the bill?

Health Service at the University

Mr. Milton R. Mehlhouse (Madison): I am not representing anyone. I am here solely for what I believe is in the public interest. I won't take much of your time. I want to call to your attention a set-up we have at the University now. These students pay, as a part of their fees, a charge which goes into a fund, and out of that fund the University pays the expense of maintaining a health service for all students. I want to read just briefly from this pamphlet, "New Plans for Medical Service." The Northern Pacific Benefit Association has been in existence since 1882. Its members consist of employes of the Northern Pacific Railroad. There are a limited number of employes. The Railway Express Agency employes, employed exclusively by the Northern Pacific lines, have received hospital services financed by monthly payments of 1 per cent within a range of 75 cents to $1.50 per month. Recently they were paid $5,000 per month for injuries. Members here received all medical and hospital services required without any additional cost. It provides deep X-ray, radium therapy, etc. The members also are entitled to burial expense of $75. Dependents are not covered. Many of them do receive care, however. The total income for 1938 was $539,641.10; the expense was $545,000, leaving a deficit which resulted from payment of $12,000 old age benefit and taxes under Social Security, etc. Thank you, gentlemen.

Chairman Hanson: Are there any other appearances for the bill. Does the author wish to appear on it?

Assemblyman Westfahl: Only to say I am in favor of it and am going to work hard to pass it through.

Chairman Hanson: Are there any other appearances for the bill? If not, we will hear those who are opposed to it.

Mr. C. H. Crownhart (Madison): I am secretary of the State Medical Society of Wisconsin. The bill that follows also is by Mr. Westfahl, and much of what I have to say on bill 327, A. is also applicable to bill 333, A. Perhaps the committee would like to hear the proponents of that bill, as well, and I can combine my appearance on them.

Chairman Hanson: Will you gentlemen give your appearance on both bills, when the next bill comes up? Are there any other appearances against this particular bill?

The Christian Science Publishing Committee

Mr. George B. Skogmo (Milwaukee, former state senator): I am appearing in behalf of the Christian Science Publishing Committee of this state, and, in addition, I wish to appear in opposition to the bill individually, as a citizen and a taxpayer.

First, I want to address myself to the bill as a representative of The Christian Science Publishing Committee. Suffice it to say that we have no quarrel with anyone who may want health insurance of any kind. However, the last speaker spoke of compulsory insurance. Compulsion is sometimes all right, but here we have a bill which compels the citizens of this state to accept treatment and healing from one single school of medicine or treatment of the sick. A large group of our citizens strongly believe in and seek relief from their bodily ailments through the use of chiropractors. There are other schools of treatment, and they are all barred here. Every one of them is barred from participation in this bill unless they want to accept the one single method.

If this bill is recommended for adoption, I have two amendments prepared to take care of what we are primarily interested in. Then the legislature can adopt the amendments to the bill, if it is to be passed. If passed without the amendments, it should be indefinitely postponed.

I don't believe I want to take time to read these amendments because there are so many others to be heard here. I will just hit the high spots. I would

like to go into this in some detail if time permitted. Personally, I think it is badly drawn, very badly drawn. It starts on the premise that medical care is a primary necessity of life in this state,—correct. Then it goes on to say that "the legislature finds"—I don't know how the legislature can possibly make this finding except upon a study of this very highly debatable question,—"finds and declares that a very considerable proportion of the population of this state does not receive a proper or adequate health and medical care, that as a consequence hundreds of deaths occur needlessly each year, thousands of cases of illness occur which could have been prevented, many individuals suffer from preventable or remediable conditions and of afflictions which impair their vitality, health and efficiency as workers and as citizens."

Tremendous Subject Matter

Now, that is debatable. As to what percentage or how many are neglected, that is highly debatable and cannot be determined without careful and conscientious study. As to the shortage of medical care, that is one question that has to be considered; the care that is to be given is quite another question. This subject matter is tremendous as it is here. It is a tremendous sum of money, and a tremendous policy. Under no circumstances, in my opinion, should the legislature adopt this premise. It is of such importance not only to the various classes involved but for the entire state, that a committee should make a careful study and determine the lack of medical care we are led to suppose exists, and to study the ways and means of filling the gap that does exist, and I don't believe the system provided for in this bill is the best way.

Another thing: This bill excludes agricultural labor, domestic servants in private homes, etc. Well now, in my opinion that appears in this bill for one purpose only. That is the purpose of putting the farmers to sleep until this bill is passed. We know that as a matter of fact when it is passed that exclusion will soon be taken out and the farmers will be dragged into it. I think that should be considered in adopting a system which would drag everyone into this dragnet of accepting one sole school of medicine or one method of receiving relief from bodily ailments and ills.

The bill is also unique in this: It provides for 2 per cent from the employer and 2 per cent from the employe. I think we have to stop and see just where we are heading. We have every imaginable tax that has ever been devised by state and federal governments. There is Social Security, Victory Tax, income taxes that mount to the sky, and on top of that we would have this tax where the man is taxed to the absolute limit and would contribute still another one running into millions or hundreds of millions of dollars of funds to be expended, and all of that would come out of the taxpayers' pockets, both employers and employes, and, in addition, whether they want it or whether they don't.

There is a tremendous group who would be barred here,—those who would seek other methods of relief, such as chiropractic methods. I don't know whether osteopaths come in on this or not,—perhaps they will, but chiropractors or any other school of healing other than those mentioned in the bill are completely barred. It is unjust and unfair to everybody concerned.

Selection of Director and Personnel

Another unique thing in this bill I am opposed to. It is the manner of selection of the director and the personnel. Your director is to be selected and he "shall select such medical officer from a panel of six or more physicians . . ." I am opposed to that method and that theory of government. Representatives of physicians shall be selected from a list of names furnished to the Governor for this purpose by the State Medical Society of Wisconsin. Representatives of optometrists shall "be selected from a list of names furnished to the Governor by the Wisconsin Association of Optometrists. Representatives of dentists shall be selected from a list of names furnished to the Governor by the Wisconsin State Dental Society. Representatives of pharmacists and pharmacies shall be selected from a list of names furnished to the Governor for this purpose by the Wisconsin Pharmaceutical Association or other such associations or groups as the Governor deems representative of pharmacists who are supplying drugs and medical commodities under this chapter. Representatives of hospitals shall be selected from a list of names furnished to the Governor for this purpose by the Wisconsin State Hospital Association or such other association or groups as the Governor deems representative of the hospitals providing care and services under this chapter."

In other words, this means that specific groups may submit a list consisting of one single, solitary name, and the Governor is placed under the responsibility of appointing one of them,—one who is appointed in fact, but actually one from one of these specific groups. The first time this was done in the state was about 1915, when I chanced to be chairman of the Interim Committee, and in the substitute amendment proposed they fixed the method of appointment also by certain, specific groups from lists to be submitted by these special groups, and the Governor must appoint one from that group. My theory then was, and is now, that this sort of thing has no place in our system of government. Basically and fundamentally it is absolutely dead wrong. When the Governor or other appointing power has that power and responsibility of appointing somebody, it should not be passed on to somebody else so he must certify the appointment whether he likes it or not. If some one representing such and such, or

such and such, or such and such, is suggested and he makes a free-handed appointment, well and good. But when we specify certain groups from which the appointment must be made and jammed down our throats, it is dead wrong. There are so many others here who want to appear that I don't like to take more time.

Now, as to the powers of the director. I wish you would study the powers of this director. If this bill is passed, one single officer here would be vested with tremendous power. He will say that you or I will take the kind of treatment he prescribes to you whether you want it or not, but you and I will pay for it just the same. In Wisconsin you would think that it should be fair and just to everyone in the state.

If there are any questions I will try and answer them. I wish I had more time. If this class legislation is adopted,—it never should be adopted in the first place until a thoroughly comprehensive study is made by the legislature, by an interim committee which would report back after determining whether, after all, this is the best system of affording some relief to the distressed of the state, and how it should be administered. I hope you will consider this bill seriously and recommend for adoption the amendments which I am submitting. So far as the Christian Science Publishing Committee is concerned, that is another issue. I have made my statements as an individual.

Chairman Hanson: Are there any others opposed to bill 327, A.?

Confusing Provisions

Dr. C. N. Neupert (State Health Officer, Madison): I want to call the attention of the committee to one thing here, and that is the provision where the State Board of Health is mentioned in the fund provision and again on page 3. " 'Director' means the director of the health insurance division of the State Board of Health." It provides rules and regulations, and as outlined here it seems to me there would be some difficulties. That one organization prescribes the rules and regulations seems peculiar to me, and I would say, as I view it, that it probably should be under the Insurance Commission rather than the State Board of Health. It is health insurance, and the State Board of Health has nothing to say about that. I think you might wish to consider that.

Chairman Hanson: Are there any other appearances against the bill?

Miss Grace Crafts (Chairman, Special Legislative Committee, Wisconsin Hospital Association, Madison): I wish to be registered against the bill.

Miss Elizabeth Brandeis: As to the State Board of health and the Insurance Department, this bill sets up a state fund. It hasn't anything to do with private insurance or with the insurance department, and that is what the insurance department is concerned with primarily. It would set up a separate new division of the State Board of Health. At the time the bill was originally drafted, there was much discussion as to whether to set up a new agency to administer the program, or to fit it into an existing state agency. That is sufficiently close to make it desirable to integrate it there, but it does provide for a new division under that Board.

Chairman Hanson: Are there any other appearances?

Sister Mary Bernadette, President, Wisconsin Conference of Catholic Hospitals Association, Madison, appeared and registered against the bill at this point.

Chairman Hanson: We will now close this hearing, and open the hearing on bill 333, A.

Mr. J. F. Friedrick: I am registering again for Mr. Nagorsne of the Federation of Labor.

This bill is a bill which would authorize the organization of medical cooperatives and would enable setting up of group medical services on a voluntary basis, either by people seeking medical service or by a group of doctors who wish to offer their services. The arguments made on bill 327, A. as to the need of medical care by people in the lower income group of course hold good so far as this kind of legislation is concerned also. This bill provides for a voluntary basis. At least the object is on a different basis than 327, A.

Medical Cooperatives Now Functioning

There are at the present time some medical cooperatives functioning. There are perhaps more hospital organizations functioning. Under these associations, workers or anyone else, by payment of a certain stipulated fee, can receive hospital services and have hospital bills paid for them. This bill is to allow for payment of medical costs on a budgetary basis. Thus, a group of doctors can get together in an association and offer their services on a group basis to people needing medical care; it would establish a cooperative and they could engage a number of doctors. Then they could give service to the people. In order to provide the finances, they would pay certain amounts monthly for themselves, or for themselves and their families, or could provide some other method for payment of this kind of service.

One of the reasons why this bill was introduced is because we have found that while there are some such organizations established,—for example, there is one in Milwaukee, and many workers are taking advantage of it, an institution in Milwaukee which provides medical service on payment of a monthly fee,—but we have run into a great deal of difficulty with the Medical Society using its influence to hamper that sort of service. We say it is hampered in Milwaukee because these doctors are excluded from bringing their patients into the larger hospitals in the City of Milwaukee, over whom the County Medical Society exercises a great deal of influence.

There is a hospital scheme with which most hospitals in Milwaukee are connected, but our people also go to the Medical Center and those doctors there are excluded from the larger hospitals. The hospital says, "You can't come in here and you can't have this doctor treat you in this hospital. If you do, you will have to have a different doctor, one on our staff." Of course, this means a doctor approved by the Milwaukee County Medical Society.

As a matter of fact, these doctors now offer their services to the people of Milwaukee on this budgetary basis, and some of the members of the staffs of some of these hospitals, due to pressure by the Medical Society of Milwaukee County, were removed from those staffs and they are no longer on the staffs. This bill would authorize the equipment of that sort of group service and would prevent discrimination against doctors who do enter into group plans of offering their services on a prepayment or budgetary basis. That is the intention of this bill.

I call your attention to the fact that not only in Milwaukee but also in Washington there was trouble due to the State Medical Society, and there was this same sort of discrimination. The Medical Society is against an organization offering care on a group basis and offering service.

Now I know the arguments that will be presented against this bill. We are going to be told that the patient now has free choice of physician. In the first place, he has free choice to enter this group. The group will consist of a number of doctors. There is not one individual doctor but a group of physicians. As a matter of fact, this free choice of physician doesn't amount to much because in most cases the average person doesn't know much about the qualifications of a doctor. He likes his appearance, or has heard something favorable about him, but he doesn't know anything about the qualifications of the doctor or his education.

I think you will also be told that this will break down the standards of medical practice and that you will get poorer medical service. As a matter of fact, it is the other way around. A group of doctors working together can do much more by pooling their interests in new equipment than one individual practitioner can. As a matter of fact, I think you will all recognize that the greatest discoveries in medicine and medical science have come from clinics or groups of doctors working together, with opportunities for study which the average general practitioners haven't got. It is a means, primarily, from our viewpoint, of securing lower-cost medical service by spreading it over a larger group on something of an insurance plan. Many of the people who contribute their monthly fee to this group will not have any great need for service for a long period of time. It will aid others, however, who will need more service than they are actually paying for.

We feel there ought to be an opportunity for these people to get together in order to secure the best quality of medical service they can get by prepayment or budgetary systems which will not create a great hardship on any one of them at one time. I trust you will favorably consider this measure.

Chairman Hanson: Are there any other appearances in favor of bill 333, A.?

Welfare Council Advocates

Miss Elizabeth Brandeis: I am registering again for the Wisconsin Welfare Council and ask favorable action on bill 333, A. I think the only thing I can add is that a bill like this would not be necessary if the State Medical Society had not definitely made it difficult for a type of voluntary action. There was a very modern attempt made to cope with this problem of economical medical care. There was no attempt made to regiment the medical profession in any way. There was nothing compulsory about it. It merely enabled groups of doctors, if they wished, to get together and offer prepaid medical service to groups of people and to provide care for them as they do other things in the cooperative movement. Unfortunately, in this state as in some others the medical societies have taken a very definite position in opposition to this type of program, and they have used their very considerable forces so that it has been impossible to get this kind of service adequately.

This is a very modern type of enabling legislation, and if people don't want this kind of thing they can go right on with their individual doctors with the same service they have at present. But it would enable people to pay in advance for their medical care. A doctor can't make that arrangement with them, but on a group basis it is feasible, and they could get the services of specialists instead of just the general practitioners, like at the Mayo Clinic. That is not a prepayment practice, but it is a group practice. Here is an opportunity to combine that service with prepayment, by advancing regular amounts so that if sickness strikes there will be medical care available. The Milwaukee Medical Center obviously meets a very real need, and a large group of wage earners belong to it. They are seriously handicapped, however. A group in Madison was very anxious to organize as a medical cooperative. There were two difficulties. One was that no hospital in the city would give hospitalization facilities for such a group, and, secondly, the doctors were afraid, and frankly, many of them said so, afraid to go into such a program because it would cost them their membership in their county medical society, in the State Medical Society and in the American Medical Association on the experience suffered by the group in Milwaukee previously.

It is sometimes said that the best doctors are not available in these groups. To the extent that is true, it is because of the sacrifices they have had to make, for they take a big chance if the group should happen to break up for they have gotten themselves very effectively blacklisted in the medi-

cal profession. Our State Medical Society and the American Medical Association have stated repeatedly that they are opposed to compulsory health insurance but believe the voluntary principle should be tried out. In fact, a great variety of plans should be tried out to see what meets the needs of various situations. In practice, however, they have opposed them in a very effective manner because of their tie-up with hospitals.

This bill is drafted to prevent discrimination against doctors and to permit those who wished to organize on this basis. I don't favor a compulsory system myself, in many respects. I would welcome an opportunity to see if this problem can be solved by voluntary action. Thank you.

Chairman Hanson: Are there any other appearances in favor of this bill?

Farmers' Union and the Central Cooperative Wholesale

Mr. Kenneth Orchard: I represent the Joint Legislative Committee composed of the Farmers Union and the Central Cooperative Wholesale. These are cooperative groups primarily in the northwestern part of the state. In listening to the statements made here, I cannot help but recall the truism that the lawyers like to talk of social advancement and charity, and the medical profession furnishes it. One of the gentlemen appearing against the other bill made the statement that the medical profession would not choose to work for anyone who is not for it. I don't believe that is the problem here. The people I represent are not interested in that feature. They are not charity cases. They are interested in paying for the treatment they receive. This is on the same basis as the tremendous cost of hospital care, which is cared for by hospital insurance. As I recall it, it is necessary to secure special enabling legislation before that could be organized. This is similar. It would provide for rendering service under those policies. It would provide a way for alleviating the expensive medical treatment. I think it is safe to say that no particular type of insurance exists which does not leave things to be desired. Some of them are medical reimbursement policies, frequently not extended except in special instances to actual physicians' bills for rendering service. So it is with hospital insurance. It provides payment for hospital bills. That is particularly true of Associated Hospital Service.

I think we have here an opportunity that is broad in scope. I am particularly interested in the phase of cooperatives. I don't know as to groups of doctors, but I do know from the standpoint of cooperatives that they broaden the field of service rendered and provide for hospital and actual physicians' fees. Some are interested in Christian Science, some in chiropractic, etc. I believe there have been one or two organizations in the United States that have been very, very highly successful. One that I am thinking of is the one in Oklahoma for employes of the low income group. It organized there, and they were able to furnish the community with very excellent hospital facilities. No private physician or group of physicians was interested in furnishing that particular community with hospital facilities because of the economic instability of the people. They weren't interested in spending their time and effort and getting a small return to compensate for their efforts. However, in that particular community a cooperative did go in there, and they organized very successfully in that area. One of our men from Wisconsin knows from experience, as a member of his own family was in that area. He was taken suddenly ill, was taken to the hospital, and he received the finest medical attention available. They were not necessarily specialists, but they were adequate.

I think that is one of the things we would be able to do with this bill. We have our northwestern corner of the state, and other areas like it. It is true that in this part one hears that doctors are reluctant,—and I certainly don't blame them,—to come into a community when they don't know whether they can "make a go of it." I don't blame the physicians. But I think this is one means of assisting the medical profession in being able to serve a community in securing adequate medical service. I have no doubt but what you gentlemen have in your own minds questions as to the advisability of this type of thing. The primary question now, I think, is: "Is such medical service desirable for communities and persons desiring to pay for it who may be in need of it?" I think we can agree wholeheartedly that, if such a bill is passed, it would be helpful. I feel that possibly there should be certain safeguards placed in the bill, particularly from the standpoint of the public, to prevent persons from coming into the field and selling something they know nothing about. I think probably some consideration should be given to that particular phase of the matter. If you gentlemen have any questions, I should be glad to answer them.

Assemblyman Foley: Do you have any amendment to take care of that situation?

Approval by Insurance Commission or State Board of Health

Mr. Orchard: No, I haven't. The only thing I thought was that possibly, since this is an insurance matter, or some features of it, these contracts should be approved by the Insurance Commission or, possibly, by the State Board of Health,—they should be asked or authorized to examine them in setting up the groups. I think there is something under the Security Law that requires some procedure. The people I represent are not at all interested in selling something here; they want it based on soundness and have public protection. They are afraid, as I am, that the racketeer will get into it. I would be glad to work with the committee, if they desire it.

I do hope the committee will act favorably on this, as I think it is something that is definitely needed in this state. Thank you.

Mr. Milton Mehlhouse: I am now representing the Wisconsin Electrical Cooperatives, consisting of a large number of rural cooperatives. This bill will encourage the use of medical facilities for the prevention of disease. The cost of the doctor's care will be paid for. Many are not willing to go to the doctor when something appears which might develop into something more serious later. Experience with the army in this war demonstrates that the health of our people is such that it could have been much better if in their earlier lives they had had recourse to medical facilities to prevent illness and disability. I am in favor of this bill, and I hope you will recommend its passage.

Chairman Hanson: Are there any other appearances in favor of the bill?

Wisconsin Farm Bureau Federation

Mr. Lewis Roherty (Madison): I represent the Wisconsin Farm Bureau Federation. I am interested in this bill rather from the standpoint of physicians than the details. We feel there is an effort on the part of the organizations such as the Medical Association to try and prevent people from improving their own conditions and it is taken upon themselves more than any law should permit. We are not opposed to having this regulated so it performs the function without taking advantage of the members. Whether it should be under the Insurance Commission or the State Board of Health is immaterial so long as it does not prevent the function for which it is created.

The farm people, in general, are becoming more conscious of their right to improve their conditions by group action, and they have taken to group hospitalization very readily, and it might be of interest to know that we sell hospital insurance. And so it might appear that we are insistent about procuring this sort of thing, but we only want to register what we know our people stand for. They are in favor of cleaning this situation up so if people want to engage in this on a cooperative basis, no one should have the power to prevent it. I hope something constructive will come out of this, but I don't intend to offer suggestions as to how it should be done. It is a good bill. It embodies the fundamental principles in which the Farm Bureau has a very definite standing. I would like to see Wisconsin exercise the right to group action whenever it can.

Chairman Hanson: Thank you. The next appearance. Are there any other appearances in favor of the bill? * * * If not, we will hear those opposed to the bill.

Mr. C. H. Crownhart (Madison): I am secretary of the State Medical Society of Wisconsin. I am not unaware of the hour and that there are several other appearances on these two measures. I will do my best to make my appearance brief.

". . . A System of Economics . . ."

First of all, Mr. Chairman and members of the committee, I should like to suggest that we are concerned with a system of economics, and every system of economics rests on some theory of values. The practice of medicine has as much to do with an economic system as it has to do with the social system of our country, and if it is proposed that a new system be applied to this country as a whole, it should be on the basis that it possesses values which cannot be found in the school now applicable.

All of you are familiar with the experiments of Ehrlich in the treatment of venereal diseases, in which he discarded 605 experiments, washed them down the sink, cleaned out his test tubes, and then perfected the 606th. The 605 experiments which he discarded left no residue, but when you change an economic system of our people, there is no way to wash the residue down the sink if you wish to start over again. It cannot be done because an economic system, once established, leaves permanent social residues. You cannot create a system of socialized medicine without, at the same time, creating a large government payroll, acquiring property, forming habits and attitudes, and these, once created, resist change and warp judgment.

I have suggested that the practice of medicine is as much a part of our economic system as it is a part of our social system and that before discarding one for another, the values of each must be weighed. In this case, it would appear to me that the old saying that the pasture on the other side of the fence appears a bit greener is applicable here, and that brings us rather logically to analyzing our present accomplishments to judge of their values and to ascertain the value of the present system as compared with that of a suggested system.

". . . Change is Not Necessarily Synonymous With Progress."

If medicine is characterized as conservative, it is perhaps more a tribute than an indictment. There is nothing dearer to any of us than life itself, and in providing care to the sick, we are dealing with life itself. Medicine, in its conservatism, recognizes the truism that change is not necessarily synonymous with progress.

In this country, we have attained public health accomplishments to an extent that is nothing short of miraculous. Proponents of these socialized medicine schemes say there is much that remains to be done. Certainly, medicine is the first to recognize that, but if we were to go back 100 or 200 years and see then how much remained to be done, those arguments should have been made with more validity at that time than at present. All accomplishments are obviously comparative. But in the field of medicine, we must recognize that a proposal to change a sys-

tem for the delivery of medical care involves, first, the need or the desirability of a new scheme and, second, the mechanics to be followed if the need or desirability can be agreed upon.

". . . Health Accomplishments in Wisconsin . . ."

Let us, then, look at the record of health accomplishments in Wisconsin and compare it with those of other countries,—in which, incidentally, most have some form of socialized medicine. As to the typhoid death rate: Wisconsin is among the first four states of the United States, and it surpasses virtually every foreign country in accomplishments. These comparative charts will prove interesting to you. Pneumonia: Wisconsin is among the first seven states in the United States, and it surpasses in incidence of pneumonia the records of Germany, England, France, and Italy. Tuberculosis: Wisconsin is among the first eight states. Again we surpass England. In infant mortality, only a few states have a better record. Wisconsin infant mortality is much lower than that for the United States as a whole. And other records are of comparable standing. The same general statement may be made for maternal deaths.

We heard, a few moments ago, statistics covering industrial time losses. There is an amount of industrial absenteeism, but the fact is that in Wisconsin we have the lowest rate in the United States, and in the United States we have a lower rate that virtually any other country, many of which do not count the first three days. And that may be because we do not have these various systems of socialized medicine.

It is in the memory of all of us that not so many years ago diphtheria was the scourge of our infants and families. The diphtheria rate in Wisconsin now is among the four lowest of the states of this Nation. In Polk County not long ago, we ran across the graveyard of a family which in 1882 was virtually wiped out from diphtheria. Within 30 days four children died from it. In 1941 there was but one death in the entire state of Wisconsin. The inscription on the tombstone of the last to die read, "Left Alone, A Mother." You would not find an inscription like that from that particuar cause today.

". . . Medical Care Not a Commodity . . ."

It is important immediately to recognize that any discussion of this subject centers about what I would call an indisputable fact: that the delivery of medical care and its allied services is not the delivery of a commodity. It is not the sale of an inventory of shelf goods in a hardware store, or a grocery store. It is the sale of highly skilled and trained services which have been envolved since the early days of medicine. It may be true that all humans are created equal and are in the Image, but certainly no one would say that we humans are cut to a pattern or cast in a single mold. That same fact faces the medical profession in the care of the sick. All men are not sick at the same time, nor in the same way. What is one man's bread or meat may be poison to another. A man may suffer from one of the many different types of pneumonia, but the medical care prescribed for him might not be the type indicated for another, even though both had the same type of pneumonia. The general practitioner of medicine does not contribute to the record of Wisconsin or the record of the United States by working on an eight-hour shift, but by being available at his office, home, or hospital at any time of the day or night. He is ever on the "swing shift." He must receive calls from morning till midnight, and he must be readily available at all times.

Physician-Patient Relationship

There is no way that patients can pass through the doctor's office and have him prescribe standard doses of medicine. Therefore, a definite personal relationship must prevail between the physician and his patient. In all of this, it should be recalled, as Mr. Friedrick stated, that the individual layman today does not pick the service he wishes delivered to him. Rather, he picks the individual whom he wishes to deliver the services, and the average judgment of the average layman is based upon his judgment of the physician. I may be ill, and what the physician may be required to do for me is something which I necessarily must leave to his own judgment,—it is the confidence I hold in that individual physician which gives me a sense of the value of the service I am obtaining. Those, I feel, are basic considerations to a discussion of these bills today. I have stated them as briefly as I could. One could write an entire book on the relationship of the medical man to the individual patient and why that relationship means so much today. But, let us apply these general considerations to the bills.

First, let me discuss Bill 327, A. on compulsory health insurance. It is a long bill. It is detailed, and necessarily so. Those facts are among the reasons why we object to the measure. You will note from the bill, on pages 8 and 9, lines 178–180, and on page 13, lines 291 to 294, that provision is made fixing a rate and specifying the income from which all medical care is to be delivered. Then you will note elsewhere that certain segments of our population are to be excluded. It excludes domestics, casual labor, agricultural labor and, incidentally, excludes anyone earning over $3,120 per year. In addition to this group, also excluded is anyone on the federal or state payroll, and that includes anyone working for government units of that general type. I believe it is true,—and I won't go into the basis for that conclusion, although I can do so,—that after excluding some 450,000 workers under the terms of

the bill, there are approximately 837,000 people in Wisconsin who would make contributions under this bill of 2 per cent.

Assemblyman Hammergren: How many?

Mr. Crownhart: 837,000 workers. In order to estimate complete coverage, I think perhaps the Industrial Commission could multiply that figure by two and one-third, so that in effect this bill would cover approximately 2,000,000 people in Wisconsin. That is, 2,000,000 out of 3,100,000. On the basis of an average income of $1,000 per earner, and after careful statistical studies, we believe the bill would raise initially about $33,600,000 a year to subsidize the promised service. This would mean, roughly, $17 per covered person, using "covered person" as distinguished from the individual who makes the payroll contribution.

Seventeen Dollars Per Individual

Every study of the cost of medical care that has been conducted has indicated an individual cost of medical care far in excess of $17. The latest one, as I recall it, was published around 1938 and stated that the cost of medical care in relation to this particular bill would be somewhat in excess of $20 per individual. In our own experiments in Wisconsin, we have found that $33 per covered person was inadequate. Obviously, $17, whatever figure you measure it by, is inadequate to provide the complete coverage that is offered here. And that $17, which this bill provides, must include administration as well. From that $17 it thus is necessary to deduct approximately no less than 20 to 25 per cent for administration and for the necessary reserve that must be set up in the event some type of epidemic in the state is encountered. That makes the sum that is available for the medical care itself about $12.75 per person. Obviously, that is a grossly inadequate figure and an imposition upon the judgment of the people of this state who would set out to buy that service by contributing 4 per cent of their earnings,—because that money comes out of our pockets,—feeling that they would only have to open the doors at any hour and this medical care would flood out upon them. I think this is a consideration which should receive the serious thought of this committee.

In the establishment of the fee to be paid, still another very real problem is created. It is not easy to raise the rates once they are established. We have that same proposition in our income tax. Where income tax rates are once established, it is very difficult to increase them, no matter how great are the needs of the state. And it is the same proposition here. The rates are fixed by the bill. The bill promises the care, but it is another thing for the administrators to come back to the legislature and put them under pressure for increased contributions.

Medicine does not stand still. Virtually overnight, insulin came into being to save tens of thousands of lives. The sulfa drugs have accomplished much over the last few years. And yet with funds insufficient to begin with, no provision is made to provide for new developments in medicine.

Still another factor involved is based upon balancing the budget here,—and an artificial one at that,—against the needs of the people themselves. It does not seem to medicine that you can balance the amount of medical care within the artificial limits of a budget in the face of records such as I have shown you here. Service, in this bill, is not based upon any comparative ability to pay. I believe I heard some one here characterize it as providing for the low income group. It is a very difficult question, gentlemen, to determine who constitutes this low income group. A man who is married, has three children, and is earning $3,000 to $4,000 a year may be closer to being in the low income group than the single individual without responsibilities earning little more than $1,000.

". . . A Type of Dictatorial Power."

Now let me turn to another phase of this type of legislation. All the way through this bill, page after page is devoted to the rule-making powers, qualifications, disqualifications, the fact that panel physicians may be removed and so on. The care of the health of the people of this state who need it is subordinated and subjected to a type of dictatorial power. In any system such as this, including these powers to regulate includes the power to destroy as well.

Curiously enough, on page 25 of the bill, the dictator established has the power to hold hearings, and without paying any attention to the laws of evidence, and without particular regard for rules of equity, he may discard physicians, he may discard the osteopath, or a nurse in the hospital. Yes, gentlemen, for the purpose of assuming dictatorial powers under this bill there are no rules, but for the purpose of making the dictatorial powers effective there are plenty of rules.

Then, having given you the highlights as to those major objections, there are three others. Because it is recognized that funds may prove inadequate, there is provision in the measure (page 8, line 169) that both the amount as well as the duration for which benefits may be provided may be reduced in the discretion of this administrator. Think of it! The individual sets out to secure and pay for complete medical care in time of need, and yet the dictator may reduce those benefits as his discretion dictates. *The director is not governed by the health needs of the people but by the necessity of balancing the bank account.*

Under this proposal, the maximum cost of health care is established. The ceiling for medical care is set and set there permanently. Then, as I pointed out, under this bill a tremendous sum of money is raised and still is wholly inadequate for the purpose. Think what this means from an administrative

standpoint. I am not altogether familiar with the amount of the annual state budget, but the budget for the State of Wisconsin is, I think about 36,000,000 a year. Under this bill alone virtually that same amount would be raised. But note this: In studies conducted in Germany prior to the war, the incidence of care under compulsory sickness insurance was found to be all the way from 35 to 54 per cent. That means that under this proposal where 2,000,000 people are covered, there would be as many as 1,100,000 cases per year. That requires filing systems,—stacks and stacks of files that would be distributed about the state, because it would take so long to have files sent from Madison that a patient would either be recovered or dead before they got there. The files have to be certified. There are investigations. There are complaints. There are adjustments. And in the experience abroad, it is found that approximately one administrative official is required for every 100 people covered in the system.

It would take a selective service system to secure, in this state, the 20,000 to 25,000 administrative employes who would be required, and those 20,000 to 25,000 individuals would be using at least 25 per cent of these funds for which the people thought they were purchasing medical, hospital, dental and other allied services.

Medical Profession the Real Insurer

Now, finally, it is very significant that in this bill there is a provision making the medical profession of the State of Wisconsin, together with our hospitals, dentists and nurses, the real insurers. That is made clear by a provision on page 20, lines 459 ff., that physicians may be paid on a fee or per capita basis, or both. *That means that if the funds are insufficient to stay within the fee schedule set-up, the doctor would have to be paid on a per capita basis, and the real reserve is the manpower of physicians and those with whom he works.*

It has been said here that this bill should be passed because it is a question of the state's interest versus the national interest. I think perhaps the federal government, in the final analysis, will be as much moved by the real facts in the proposal as the State of Wisconsin would. I am quite sure that to "beat the federal government to it" is no reason for Wisconsin to be the first to adopt compulsory sickness insurance.

Now with this brief summary of the principal objections, let me turn to the second Westfahl bill.

Bill 333, A

Bill 333, A. contains the magic word "cooperative." The initial section of the bill relates to the so-called Declaration of Public Policy. One of the first things on page 2 is that "the legislature finds and declares that a very considerable proportion of the population of this state does not receive a proper or adequate health and medical care, that as a consequence hundreds of deaths occur needlessly each year," etc. I do not believe that our health record, which I have discussed with you, indicates that to be a fact.

Then it says, on page 2, "The legislature finds and declares that large numbers of people in the state of Wisconsin are unable to secure adequate medical and hospital care because of insufficient means to meet the high cost thereof and because no arrangements exist for spreading the risk of medical and hospital expense over groups of people and periods of time."

I am certain that the people who drafted this bill do not mean that at all. One hundred three insurance companies in the State of Wisconsin are writing accident and health insurance, paying in cash benefits, and are subject to regulation by our state Insurance Department.

Also, on page 2, a statement is made that the legislature finds and declares that the cost of medical and hospital care "can be reduced" by setting up a system such as this. Again, I do not believe they mean that. Perhaps some social arrangement would spread the cost, but the administrative factor in any widespread plan would doubtless increase the cost rather than reduce it.

". . . Denial of Hospital Facilities."

On page 2, there is reference to denial of hospital facilities. The hospital facilities in the State of Wisconsin have been built up as a result of voluntary hard work over a period of many years. There is regulation in every hospital as to who may practice therein. A young medical graduate, until he has been out a certain period of years, cannot perform major surgery without being under the supervision of one more experienced in that field. All of those rules and regulations have been built up in our state, and in virtually all 48 states, without the necessity of resorting to legislative action. This is also true of the medical schools which have adopted increasingly higher standards in recent years,—standards which have been obtained as a result of good hard work. Yet, this bill would put the hospitals, the osteopaths and the medical profession, and the laymen, on such a basis that they would not dare refuse to deal with any individual who might be connected with such a scheme. That does not seem to us to be conducive to sound health advancement in Wisconsin.

There is a similar provision at the top of page 4. There could be no criticism whether these plans were organized by physicians, laymen, or other individuals, regardless of their value and regardless of the fact that these plans might not be paying out.

Again, the State Medical Society, representing the medical profession in this state, feels that this

type of legislation is not in the interests of the public health, and I feel this committee will recognize some of the problems contained in this bill.

". . . Mass Production of Medical Care . . ."

In summary, if this type of organization were to be allowed, I think there are at least five real dangers to be noted. First, it creates a tendency on the part of any organization of this type having a contract with a single physician or osteopath, or two or three in a group, to develop mass production of medical care and to hold the services available down to the physical resources of the physicians. Now, gentlemen, when you and I buy insurance, such as life insurance, we buy that insurance on the basis that when the need arises the funds will be there. But the funds canot be there when it is not actually funds that are being paid out, but services. You cannot take the productive work of the medical profession, add it up as reserve, and pay it out. Perhaps some of them will die. Perhaps some will be in military service. If I buy sickness insurance, or health insurance, it is on the basis that over the span of years when I may need it, it will be available to me.

Second, this type of mass production cannot involve that same type of personal relationship between the physician and the patient that exists in this country. Much the same developments occur which I outlined in connection with the bill for Compulsory Sickness Insurance—rules, regulations, lay director, ad infinitum.

Third, if the premium is inadequate to pay for whatever amount of service is rendered, immediately administrators do not want to raise the premium but lower the quality and quantity of the service. Either that takes place or they will "hook-up" with some other type of sales proposal that will make money in order to meet the deficit. Fourth, this type of proposal would mechanize medicine for the average case. Each patient knows how sick he is, and so does his physician. You cannot average these cases. You cannot just balance the budget and run away.

Medical Care Not Comparable to Sale of a Commodity

Finally, I would suggest that quality in medical care is not comparable to the sale of a commodity such as milk. You can't just wake up in the morning and take it in out of the sun and put it in the refrigerator until needed. Medical care is trained, it is specialized, and based on individual ability as much as anything else. You cannot use one X-ray to serve a purpose not intended for it. You must give the physician all he needs to find out what is the matter with his patient.

Even our government, I think at times, has no interest in this type of legislation. Those who would have us develop a new system of medical care in this country have no confidence in any voluntary scheme. We, of the medical profession in this state, have expended thousands of dollars of our own resources, and hour after hour of time of the secretary's office, in studying reports, in reading the type of propaganda that is submitted by propaganda sources, and in carrying these proposals into the field. We have tried them in Superior and in Milwaukee. At the present time we are negotiating with the Farm Security Administration to see if we can cover Farm Security Administration clients in two northern Wisconsin counties. At the present time we are also negotiating with labor groups in eastern Wisconsin to see if we can cover some 3,000 laborers in that field.

We have heard that the average individual does not budget ahead for the possibility of need in the future. That is the very argument we heard here a while ago sustaining the need for compulsory sickness insurance. Apparently it is that argument which motivates the committee of the National Health Conference when it said as to voluntary and other efforts, "The proof of their value, however, is not their good intentions but their actual accomplishments in securing coverage," and ". . . The Technical Committee on Medical Care cannot find the answer to the Nation's problem in voluntary insurance efforts."

The Beveridge Report

Now, gentlemen, just about two minutes more. I do appreciate your patience. We have heard much of the program which has emanated from our National Resources Board in Washington. I have not been able to secure a copy of it as yet, but I have a photographic copy of The Beveridge Report. I have indicated to you in my arguments that private medical practice would be virtually abolished under this type of proposal. Sir William Beveridge, in his famous "Cradle to Grave Report," says: "If a contribution for medical treatment is included in the insurance contribution, contributions will cover not 90 per cent of the population, but 100 per cent of the population. This will not, of itself, put an end to private practice. Those who have the desire and the means will be able to pay separately for private treatment, if the medical service is organized to provide that. . . But no one will be compelled to pay separately. The possible scope of private general practice will be so restricted that it may not appear worth while to preserve it."

I suggest to the committee that in dealing with measures of this type, you cannot draw the analogy between unemployment compensation insurance, which pays in cash benefit, and the service benefits of the type proposed in delivering medical care. And while this would be a service by physicians physically underwritten by physicians, it inevitably means that all medical care trends would be gov-

erned by payrolls and all else that is implied in these fields. I have just secured and read a report on compulsory sickness insurance by Professor Simpson of Northwestern University. After suggesting that there is a need to extend the present social security program both horizontally and vertically to include those not now covered, he said, "But real social security means security in the carrying on of useful activities and in the pursuit of progress. We don't want a security that stagnates. We don't look forward to a condition in which everyone will be sitting idle in a public housing project; bringing children into the world with the aid of maternity benefits; rearing them under the care of a school physician and a visiting nurse; receiving unemployment benefits when well and sickness benefits when ill; drawing a disability allowance at fifty and an old age annuity at sixty; with his family looking forward complacently to survivors' pensions when he has finished his sitting and gone to his further reward. There must be a better way of life than that, and we believe the American people will insist on finding it."

In conclusion, I would suggest to you that these reports, characterized as suggesting coverage from "Cradle to Grave," or, as one person has said, from "Womb to Tomb," if adopted, could still-birth a nation. Thank you very much, gentlemen, for your patience.

Chairman Hanson: Thank you, Mr. Crownhart.

Wisconsin State Dental Society

Dr. R. W. Huegel (Madison): Mr. Chairman and members of the Committee, I should like the privilege of speaking on both bills. I am legislative chairman for the Wisconsin State Dental Society. I refrained from making any comments until Mr. Crownhart finished. I feel that he covered this very thoroughly and accurate, and the Wisconsin State Dental Society endorses everything he has said.

In commenting on bill 327, A., I think it is safe to say that Mr. Crownhart has gone into the statistics very thoroughly, and speaking for the dentists, I think you can see where they would come into this picture. If this measure provides for the so-called low income group, you can see that it is just out of the picture. There just isn't any such group. I think we have such a period now.

We must think in terms of preventive medicine. The dental profession is always mindful of its responsibilities to the public. We have come a long way in practice the last few years. Dentistry has been for the public. At the present time, the American Dental Association, operating through a subcommittee of the Council on Dental Health, is making a careful survey of dentistry and this low income group. Dr. Wilson, assistant dean of the Marquette University School of Dentistry, has assured me that Wisconsin is cooperating in that study and will take part in it. It seems to me that when you think in terms of dentistry, it just isn't in the picture.

As to bill 333, A., for a prepayment plan, that has been tried many times. It has been tried by many men in private practice in dentistry. It doesn't work,—it is a complete failure. I can cite many instances of it. One case was in this city where they tried a prepayment plan. The result was that the quality of dentistry deteriorated to a point where we called it "slapstick dentistry." And that isn't what we want for the public. We feel that neither one of these two bills is worthy of very much consideration, and we hope you will see it that way. Thank you very much.

Assemblyman Finch: I should like to ask you a question.

Dr. Huegel: Yes, sir.

Assemblyman Finch: Do you contend that this type of set up for dentistry possibly would encourage, rather than prevent, decay?

Dr. Huegel: It would not encourage the filling of teeth and keeping them in repair. I can't see it any other way. It does nothing but tear down. When you study the statistics of this bill, there is nothing left for good dentistry,—nothing.

Chairman Hanson: The next appearance in opposition?

Sister Mary Bernadette (President, Wisconsin Conference of Catholic Hospitals Association, Madison): I should like to register our opposition to this bill.

Chairman Hanson: The next appearance.

Health and Accident Medical Conference

Mr. John Keelan (Milwaukee): I am legislative representative for the Health and Accident Medical Conference. I do not wish to talk on this bill. Mr. Crownhart has discussed it, but I am opposing the bill on the grounds of the basis of compulsion for state insurance, and at the same time it serves notice that it would brook no regulation from our insurance department. I question very much the opening statement of the bill as to the legislature being able to find any circumstances as to the people of Wisconsin not receiving medical care. This bill does not take the people into consideration at all.

Something was said by the proponents of the bill to the effect that something like 4 per cent of the absenteeism was caused by injury. And here we are proposing a 4 per cent tax on the payrolls of the state of Wisconsin. In other words, it is taxing the payrolls of 96 per cent of the wage earners to the extent of 4 per cent to pay the medical bills of only 4 per cent of our people. That is economically ridiculous. I have nothing to say on bill 333, A., other than to register opposition to it.

Chairman Hanson: You are appearing on bill 333, A. too?

Mr. Keelan: Yes, sir.

Chairman Hanson: Does anyone else wish to appear on bill 333, A.?

Sister Mary Bernadette: I would also like to take exception to the statement made that hospital service has been refused in Madison because of pressure on the part of the medical profession. The private hospitals always maintain an independent status, and they are not subject to any doctor or group of doctors. They are always interested in the welfare of the people, and many doctors have been excluded from private hospitals because of lack of care and not because the hospital is representing the medical profession.

Chairman Hanson: Are there any other appearances in opposition to this bill?

Miss Grace Crafts (Madison): I am representing the Wisconsin Hospital Association, and desire to record its opposition to these measures.

Chairman Hanson: Are there any other appearances as to either bill 327, A. or 333, A.? If not, the hearing is closed.

ANALYSIS OF BILL 333, A.

1. Permits, under the name "cooperatives,"

   Laymen to organize to purchase, and provide for the delivery of, medical and hospital care for themselves and families. Page 4, Sec. 4, lines 6 and 7.

   A single physician or osteopath, or a group of physicians or osteopaths to organize to sell medical and hospital care. Page 4, Sec. 4, lines 8 and 9; also P. 2, lines 21–22.

2. Legalizes

   Any contracts based on periodic payments of stipulated sums (insurance basis) for the rendition of hospital service, or medical service, or both, and whether by an individual, a cooperative, a partnership of professional or nonprofessional men, or other similar group.

To assure that there be neither direct nor indirect interference with the promotion of such plans or organization of groups to promote such plans, this bill:

1. Prohibits

   Any public hospital, or any hospital having partial or complete tax exempt status (charitable institutions) denying to a patient, because he is enrolled in such a plan, the facilities of the institution.

   Any such institution denying a physician, because he is participating in such a scheme, the use of its staff facilities, or facilities available for hospitalizing patients.
   Violation of this provision would be a misdemeanor. P. 2, lines 29ff.; P. 3, lines 40–43.

   Punishment: a fine of not less than $100 or more than $1,000.

   Any county medical society or the State Medical Society from excluding a physician from membership who, otherwise eligible, participates as an individual or in a group to furnish medical service on the voluntary sickness insurance basis. P. 4, lines 2–15.

2. Exempts

   Any plan so organized from any regulation whatsoever under the insurance laws of Wisconsin. P. 6, Sec. 5.

3. Provides

   When patients receive medical or hospital service or both under such an organization, the responsibility of the hospital and the physician duly involved is direct to the patient and their duties shall remain the same as though such an arrangement had not been made, except as to the payment of bills. P. 5, lines 16–26.

4. Punishes

   By fine or imprisonment, or both, any person, partnership, or corporation which directly or indirectly interferes with the operation or organization of such a so-called cooperative. Denial of medical or hospital facilities to a patient enrolled in such a venture would be deemed prima facie evidence of such obstruction. P. 5, line 34 to P. 6, line 44.

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MERRY Christmas?

You are a healer, a saver of life . . .

Yet, this Christmas you see a world intent on maiming, on killing.

You wish you were out where the wounded and dying are, doing everything in your power for them . . .

But, circumstance holds you and commands, "Stay, do your work here—where the need for it is greater than ever before!"

Because today twice as many people are dependent upon your skill, no hour of day or night is completely and certainly your own...

Not even at Christmas.

So, to wish you a *merry* Christmas at this time would be to wish you the impossible.

However, the House of Wyeth—dedicated, too, to the relief of suffering—does wish that on Christmas Day you find a moment to yourself . . .

To hope, to believe, that this time the maiming and killing of war are being endured for the last time . . .

To be thankful for the wonderful healers and healing techniques that are coming out of the war to serve the peace . . .

To take pride in the glorious achievements of your professional brothers in uniform . . .

And to feel that your own service, wearying and unheroic though it be, is appreciated and in the finest traditions of the selflessness of the medical profession.

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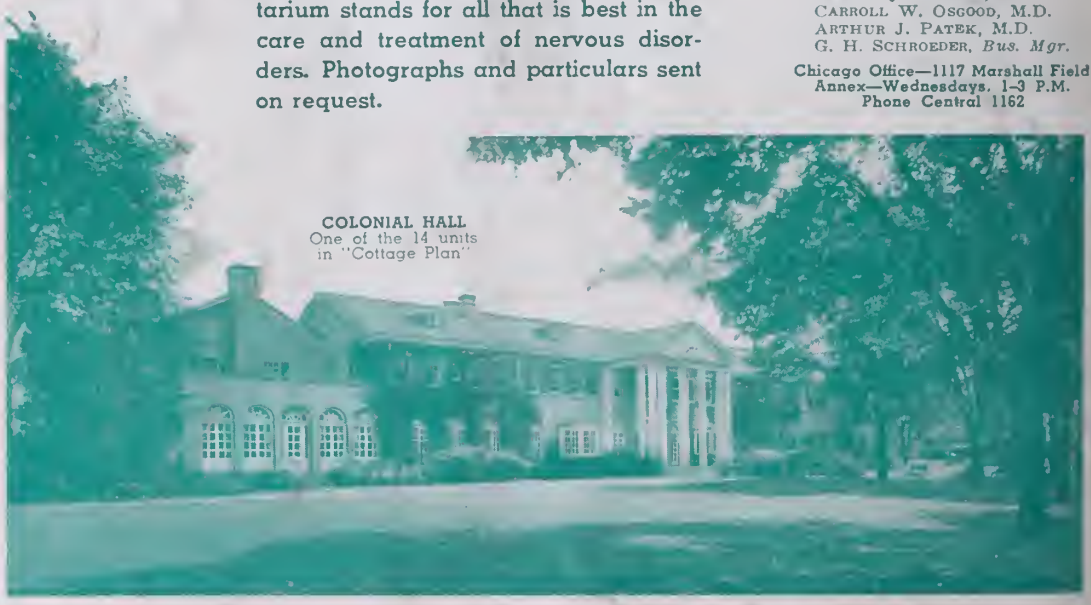

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